

**Medicaid 1915(c)
Home and Community-Based Services Waiver
for
Individuals with Developmental Disabilities or Mental Retardation**

**STATE IMPLEMENTATION PLAN
(as amended)**

**effective
July 1, 2003**

**Long Term Care Unit
Division of Health Care Financing
Utah Department of Health**

**Approved by
CMS Region Office VIII
April 2004**

MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER

STREAMLINED RENEWAL FORMAT

1. The State of Utah requests 5-year renewal of its home and community based waiver, number 0158.90.R1.02.
2. All services in the renewed waiver are the same as those described in the original waiver (as amended).
 - a. X Yes.
 - b. No. The following services are removed from the renewal request.

 These services are now available in at least that amount, duration and scope under the State plan. Specify the services and any State plan limitations.

<u>SERVICE</u>	<u>LIMITATIONS</u>
----------------	--------------------

 These services were not utilized under the original waiver and are no longer needed.

- c. No. The State requests changes in the service package or the manner in which the services are to be provided. Description attached.
- d. No. The State has added the following services (Descriptions and provider standards are attached.):

3. All eligibility requirements and procedures described in the original waiver will remain in effect under the renewed waiver.
- a. X Yes.
- b. No. A description of all changes is attached.
4. All assurances and information in the approved waiver as required by 42 CFR 441.302(a) - (f) remain in effect, including all amendments approved by HCFA.
- a. X Yes, with no changes.
- b. Yes, but with the following changes:
- Provider qualifications (including licensure/certification) are different. The revised standards are attached.
- Changes in level of care assessment process, team, and/or instrument. Description and copies of revised forms (if applicable) attached.
- Changes in care planning process, team, and/or instrument. Description and copies of revised forms (if applicable) attached.
- Revised implementation procedures/forms. Description/forms attached.
- Other. Description attached.
5. Per capita expenditure estimates, consistent with 42 CFR 441.303(f) are attached for each year of the renewed waiver. The State has used Appendix G of the Streamlined Application Format to prepare these estimates. These data are consistent with data supplied to and accepted by HCFA on form 372, except where noted and fully explained.
- *note: Figures from approved HCFA form 372 for FY99 were used to compute D` ,G and G`. Figures from the current waiver amendment were used to compute D, since no costs for new services were available. Those costs will be updated in next years 372s report.**
6. Attached is documentation to support a conclusion that the State has taken appropriate corrective action to resolve each problem area identified through Federal monitoring activities, or through the independent assessment of the original waiver.
- a. Yes.
- b. X No. There are no outstanding problem areas in this waiver. Corrective action is not necessary.

7. This document, together with the original waiver and all amendments approved by HCFA, constitutes the State of Utah's request for renewal of its home and community based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver, as amended and renewed, and certifies that any further modifications to the waiver request will be made in writing and will be submitted by the State Medicaid agency. Upon approval by HCFA, this waiver renewal request will serve as the State's authority to provide home and community based services to the target group under its Medicaid plan. Any proposed changes to the approved renewed waiver will be formally requested by the State in the form of waiver amendments.
8. The State assures that all material referenced in this waiver renewal application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.
9. The State chooses to perform an independent assessment of its renewed waiver, as permitted by 42 CFR 441.303(g), for the period of the renewal. This assessment will evaluate the quality of care provided, access to care, and cost-neutrality of the waiver
- ____ Yes X No
10. The State requests an effective date of July 1, 2000.
11. The State contact person for this waiver renewal request is John Williams, whose telephone number is (801) 584-1914, or Kelli Polcha, whose telephone number is (801) 538-7069.

Signature: _____ \ s \

Print Name: Michael Deily

Title: Director, Division of Health Care Financing

Date: March 31, 2000

STATE OF UTAH
MEDICAID 1915(c) HOME AND COMMUNITY-BASED SERVICES WAIVER
for
PERSONS WITH DEVELOPMENTAL DISABILITIES
OR MENTAL RETARDATION

SECTION 1915(c) WAIVER FORMAT

1. The State of Utah requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

<u> </u>	yes
<u> X </u>	no

If yes, the State assures that no more than 200 individuals will be served on this waiver at any one time.

This waiver is requested for a period of (check one):

<u> </u>	3 years (Initial waiver)
<u> </u>	5 years (Renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

<u> </u>	Nursing facility (NF)
<u> X </u>	Intermediate Care Facility for people with mental retardation (ICF/MR)
<u> </u>	Hospital
<u> </u>	NF (served in hospital)
<u> </u>	ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

_____ aged (age 65 and older)
_____ disabled
_____ aged and disabled
_____ mentally retarded
_____ developmentally disabled
 X * mentally retarded and developmentally disabled as
defined in 42 CFR 483.102(b)(3) and 42 CFR 435.1009

* This waiver is limited to persons with disabilities who have established eligibility through the Utah Department of Human Services for state matching funds in accordance with UCA 62A-5-103.

_____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested in order to impose the following additional targeting restrictions (specify):

_____ Waiver services are limited to the following age groups
(specify):
_____ Waiver services are limited to individuals with the
following disease(s) or condition(s) (specify):
_____ Waiver services are limited to individuals who are mentally retarded
or developmentally disabled, who currently reside in general NFs, but
who have been shown, as a result of the Pre-Admission Screening and
Annual Resident Review process mandated by Public Law 100-203 to
require active treatment at the level of care of an ICF/MR.
_____ Other criteria (Specify):
 X Not applicable.

5. A waiver of the "statewideness" requirements set forth in section 1902 (a)(1) of the Act is requested.

_____ yes
 X no

If yes, waivers will apply only to individuals in the following geographic areas or political subdivisions. (specify):

6. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to waiver recipients.
7. The State requests that the following home and community-based services, as described and defined in appendix B.1 of this request, be included under this waiver:

<u> X </u>	Support Coordination
<u> X </u>	Community Living Supports
<u> X </u>	Personal Assistance
<u> X </u>	Personal Emergency Response Systems (PERS)
<u> X </u>	Environmental Accessibility Adaptations
<u> X </u>	Chore and Homemaker Services
<u> X </u>	Supported Employment
<u> X </u>	Site and Nonsite-Based Day Supports
<u> X </u>	Senior Supports
<u> X </u>	Transportation Supports
<u> X </u>	Latch Key Supports
<u> X </u>	Family Assistance and Support (Family Support)
<u> X </u>	Respite Care Supports
<u> X </u>	Self-Directed Supports
<u> X </u>	Educational Supports
<u> X </u>	Specialized Medical Equipment/Supplies/Assistive Technology
<u> X </u>	Specialized Supports

8. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
9. Eligibility groups included under the waiver are reflected in Appendix C-1.

Waiver recipients meet the appropriate State plan requirements for the eligibility groups included under the waiver unless § 1902(a)(10)(C)(i)(III) has been waived in order to use income and resource rules for the medically needy. Under a medically needy waiver of § 1902(a)(10)(C)(i)(III), you may apply eligibility policies that differ from those normally used to determine eligibility for individuals who are living in the community. The income standards and methods employed for the medically needy under this waiver do not result in individuals' income exceeding the Federal financial participation limits of § 1903(f).

- A. A waiver of § 1902(a)(10)(C)(i)(III) is requested.

<u> X </u>	yes
_____	no

B. Computation of income for purposes of Federal financial participation limits is based on one of the following. Check all that apply.

- X Only the individual's income is compared to a one person medically needy income standard when you choose to use institutional eligibility rules to determine whose income is used in determining eligibility.
- The individual and spouses' income is compared to the appropriate medically needy income standard for a family of the same size when spouses' and/or parents' income is used to determine eligibility. That is, community rules are used to determine whose income is used to determine eligibility.
- The individual and parents' income is compared to the appropriate medically needy income standard for a family of the same size when spouses' and/or parents' income is used to determine eligibility. That is, community rules are used to determine whose income is used to determine eligibility.

The income and resource exceptions applied under the waiver are described in Appendix C-2.

10. Appendix C-3 reflects the post-eligibility income deductions for individuals whose eligibility is determined under § 435.217.
11. An individual written plan of care (here after called a support plan) will be developed by qualified individuals for each recipient under this waiver. This support plan will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written support plan. The support plan will be subject to the approval of the Medicaid agency. Federal financial participation will not be claimed for waiver services furnished prior to the development of the support plan. Federal financial participation will not be claimed for waiver services which are not included in the individual written support plan.
12. Waiver services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR, except as requested in appendix B-1(a) for support coordinator discharge planning within the 30 day period prior to the recipient's discharge from ICF/MR.
13. Federal financial participation will not be available in expenditures for the cost of room and board, except when provided as part of respite care in a facility approved by the State that is not a private residence. Meals provided under any waiver service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).

14. The State will refuse to offer home and community-based services to any recipient for whom it can reasonably be expected that the cost of home or community-based services furnished to that recipient would exceed the cost of a level of care referred to in item 2 of this request.

<u> </u>	yes
<u> X </u>	no

15. The Medicaid agency provides the following assurances to HCFA:

- A. Necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those standards include:
1. adequate standards for all types of providers that provide services under the waiver (see Appendix B);
 2. assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 3. assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
- B. The agency will provide for an evaluation (and periodic reevaluations) of the need for the level of care indicated in item 2 of this request, when there is a reasonable indication that an individual might need such services in the near future, but for the availability of home and community-based services.
- C. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the recipient or his or her legal representative will be:
1. informed of any feasible alternatives under the waiver; and
 2. given the choice of either institutional or home and community-based services.
- D. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of the institutional care indicated in item 2 of this request as an alternative to home or community-based services, or who are denied the waiver service(s) of their choice or the waiver provider(s) of their choice.

- E. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
- F. The agency's actual total expenditure for home and community-based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in the setting(s) indicated in item 2 of this request, in the absence of the waiver.
- G. The agency will annually provide HCFA with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the recipients. The information will be consistent with a data collection plan designed by HCFA.
- H. The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502.

 X yes
 no

16. The agency will provide for an independent assessment of its waiver (except as HCFA may otherwise specify for particular waivers) that evaluates the quality of care provided, access to care, and cost-effectiveness. The results of the assessment will cover all but the last fiscal year of the waiver, and will be submitted to HCFA 90 days prior to the expiration of the approved waiver.

The agency requests an exemption from this requirement.

 X yes*
 no

*In accordance with the option permitted under revised waiver regulations which became effective August 24, 1994, the agency elects not to provide for an independent assessment of this waiver.

17. The State assures that it will have in place a formal system by which it ensures the health and welfare of the recipients, through monitoring of the quality control procedures described in this waiver document. Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that support plans are periodically reviewed to ensure that the services furnished are consistent with the identified needs and expressed desires of the individuals. Through these procedures the State will ensure the

quality of services furnished under the waiver and the State plan to waiver recipients. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiency.

18. An effective date of July 1, 1999 is requested.
19. The State contact person responsible for management of the waiver program is John Williams, who can be reached by telephone at (801) 538-9269. The State contact person for technical assistance for this waiver is Kelli Polcha, who can be reached by telephone at (801) 538-7069.
20. This document, together with Appendices A through G, and all attachments, constitutes the State of Utah's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____ \ s \ _____

Print name: Michael Deily

Title: Director, Division of Health Care Financing

Amendment Request Date: May 10, 1999

APPENDIX A - ADMINISTRATION

APPENDIX A-1: LINE OF AUTHORITY FOR WAIVER OPERATION

Check one:

- _____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.
- X** The waiver will be operated by the Division of Services for People with Disabilities (DSPD)*, a separate agency of the State under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.
- _____ The waiver will be operated by _____, a separate division within the single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES ROLE AND PROVIDER CONTRACTING REQUIREMENT

The Division of Services for People with Disabilities (DSPD) is the designated State Agency responsible for planning and developing an array of services and supports for persons with disabilities living in Utah. State statute 62A-5-103, 1953 as amended, sets forth DSPD's authority and responsibility to:

1. Plan, develop and manage an array of services and supports for individuals with disabilities;
2. Contract for services and supports for persons with disabilities;
3. Approve and monitor approved providers;
4. Act as a fiscal agent to receive and disburse funds; and
5. Develop standards and rules for the administration and operation of programs operated by or under contract with the division.

In accordance with DSPD's lead role and designated responsibilities, monies allocated for services for persons with disabilities are appropriated by the State Legislature to DSPD which in turn contracts with public and private providers for the delivery of services and supports necessary to implement all programs funded partially or in-full with state monies. To assure the proper accounting for state funds, DSPD enters into a written state contract with each provider

which includes a stipulation that claims for services provided be submitted to and paid by DSPD. This State-specific requirement applies regardless of whether: 1) the state funds are used for state-funds only programs or are used to draw down federal FFP as part of a 1915(c) HCBS Waiver program, or 2) the target population includes Medicaid-eligible citizens. The state contract is the sole responsibility of, and is managed by, DSPD's parent agency, the Department of Human Services.

In the case where a portion of the annual Legislative appropriation is designated for use as state matching funds for the Medicaid 1915(c) HCBS Waiver described herein, DSPD certifies to the State Medicaid Agency, through an interagency agreement, that the state funds will be transferred to the State Medicaid Agency in the amount necessary to reimburse the state match portion of actual Medicaid expenditures paid through the MMIS system for waiver services.

As a result of the State's organizational structure described above:

1. All providers participating in this 1915(c) HCBS Waiver must: a) fulfill the DSPD state contracting requirement as one of the waiver provider qualifications related to compliance with State law, and b) abide by the provision of the state contract to bill through DSPD for services provided.
2. The State Medicaid Agency reimburses DSPD for any interim payments that are made for legitimate waiver service claims during the time the clean claim is being processed through the MMIS system.
3. The State Medicaid Agency recovers from DSPD the state matching funds associated with the waiver expenditures.
4. The State Medicaid Agency approves all proposed rules, policies, and other documents related to the 1915(c) waiver prior to adoption by the DSPD policy board.

The requirement for state contracting with DSPD is reflected in Appendix B-2.

STATE MEDICAID AGENCY ROLE AND PROVIDER CONTRACT REQUIREMENT

The State Medicaid Agency, in fulfillment of its mandated authority and responsibilities related to the 1915(c) HCBS Waiver program, retains responsibility for negotiating a Medicaid Provider Agreement with each provider of waiver services. This requirement is reflected in Appendix B-2. Unlike the DSPD state contract required of all providers of services to persons with disabilities who receive state monies, the Medicaid Provider Agreement is specific to providers of Medicaid funded services and is standardized across the HCBS Waivers targeted to the persons with disabilities.

In order to comply with State law and federal Medicaid regulations, a billing system has been in place since 1987 that utilizes a HCFA approved extension of the State's MMIS system to process waiver service claims through DSPD. For a detailed discussion of this extension, see Appendix F. Medicaid Provider Agreements stipulate use of this system as an element of participation in this waiver.

INTERAGENCY AGREEMENT FOR ADMINISTRATION OF THE HCBS WAIVER

An interagency agreement between the State Medicaid Agency and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement delineates the State Medicaid Agency's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS Waiver rules and regulations. The agreement also delineates DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies.

The major components of the agreement are:

1. Purpose and Scope;
2. Authority;
3. Definitions;
4. Waiver Program Administration and Operation Responsibilities;
5. Claims Processing;
6. Payment for Delegated Administrative Duties (including provisions for state match transfer);
7. Role Accountability and FFP Disallowances; and
8. Coordination of DHS Policy Development as it Relates to Implementation of the Medicaid Program.

Check one:

_____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

X The waiver will be operated through an interagency agreement with the Division of Services for People with Disabilities (DSPD), a separate agency of the State within the Department of Human Services. The State Office of DSPD will administer the day to day management of the waiver program while the State Medicaid Agency will retain final authority and oversight. A cop of the administrative interagency agreement is on file at the State Medicaid Agency.

_____ The waiver will be operated by the Health Care Financing Agency (HCFA), a separate division within the single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX A-2: INTRODUCTION TO THE HOME AND COMMUNITY-BASED SERVICES WAIVER FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES OR MENTAL RETARDATION LIVING IN THE STATE OF UTAH

A. PURPOSE

This waiver document represents a substantial amendment to Utah's 1915(c) Home and Community-Based Services Waiver for Mentally Retarded and Developmentally Disabled Individuals, # 0158.90.R.1. Significant changes have been made so that the waiver might serve as a framework for the implementation of current best practice philosophies in the design and delivery of services and supports for Utahns with disabilities, including both those who qualify for and receive Medicaid waived services and those whose services are funded by non-Medicaid sources. The waiver is one means by which the Utah Division of Services for People with Disabilities seeks to fulfill its mission *to promote opportunities and provide supports for persons with disabilities to participate fully in Utah life.*

B. OBJECTIVES

This waiver is designed to meet the following objectives:

1. Promote access by waiver recipients to needed services and supports.
2. Provide supports that are adequate to assure the general health and safety of waiver recipients.
3. Maintain the health of individuals in waiver services sufficient to allow them to maintain their places of community residence.
4. Provide supports for waiver recipients to live as independently as possible in the community settings of their choice.
5. Provide supports that allow children and youth to reside with their families.
6. Improve waiver recipients' access to multiple community environments.
7. Promote the inclusion of people with disabilities in the activities and environments of their communities.
8. Foster mutually beneficial relationships among waiver recipients and people who do not have disabilities and who are not paid care givers for the purposes of expanding the natural support networks of waiver recipients and allowing waiver recipients to occupy socially valued roles in their communities.

9. Improve the waiver recipient's ability to perform activities of daily living and thereby achieve greater independence from care givers.
10. Provide the array of supports that allow the waiver recipients to demonstrate progress towards their valued outcomes.

C. PRINCIPLES

This waiver was designed to be consistent with a service delivery system that promotes and supports consumer self-determination, that maintains a high standard of quality in services and supports, and that maximizes the distribution and utilization of public funds, both federal and state. The waiver is, therefore, grounded in the following principles:

1. **Person-centered supports.** Person-centered supports are those that are articulated by the person or that directly relate to a goal, preference, or outcome that the person has identified as important. Person-centered supports, based upon quality of life as defined by the person with a disability, are superior to the prescriptions given by others who do not live with the disability. Person-centered supports reflect a shift in thought and practice grounded in the belief that the person who has the disability knows their needs and interests better than the professionals and para-professionals who come and go throughout that person's lifetime. The individual--assisted by legal representatives, family members and others in their chosen circle of support--has the authority to define the way in which she or he would like to live and the array of supports that best meets personal goals and individual needs.
2. **Consumer-driven supports.** Consumers, with adequate and appropriate information and with the assistance of legal representatives, family members, and others in their chosen circles of support, can define, decide, and direct the supports that they receive. The informed preferences of the individual waiver recipient will be paramount in the decisions relevant to the selection and delivery of supports.
3. **Shared responsibility and risk.** As consumers exercise greater choice and control over the supports they receive, they also assume relevant responsibility and accept reasonable risk associated with the decisions that they make. The manner in which the waiver recipient, the state agency, and the providers of purchased supports share the responsibilities and risks related to services and supports will be defined by support plans, contracts, and other written agreements.

4. **Cost effectiveness.** Waiver recipients will receive adequate and appropriate services and supports. Further, wherever there are multiple, acceptable support options, waiver funding will be used to purchase the most cost effective among those options.
5. **Benefit to the consumer.** Supports purchased with waiver funding will be of clear benefit to the individual with a disability.
6. **Appropriate use of public funds.** The resources that the consumer will control will be used to secure supports defined by that individual's written support plan. The consumer will be asked to use non-public resources to secure services, supports, and/or assets that are not appropriate for purchase with public dollars, and, in the case of Medicaid waiver funds, are not directly associated with the prevention of institutionalization.
7. **No duplication.** Supports purchased with waiver funding will not be duplicative of each other or of supports purchased by other funding sources, public or private.
8. **Payor of last resort.** Waiver funds will be used for the purchase of supports only after supports available through the Medicaid State Plan and all other resources for which the individual is eligible have been maximized.
9. **Qualified providers.** Those whom the waiver recipient selects to provide supports under a purchase of service arrangement using waiver funds will be adequately qualified to provide that support.
10. **Quality assurance.** Purchase of service providers, support coordinators, and others who assist in the development and delivery of supports for people served through the Division of Services for People with Disabilities will be expected to maintain established standards of quality. The State Medicaid Agency and DSPD will assure that high standards are maintained by way of a comprehensive system of quality assurance including: (a) formal surveys of providers for measurement of individual and organizational outcomes, (b) contract compliance reviews, (c) regular observation and evaluation by support coordinators, (d) provider quality assurance systems, (e) consumer/family/legal representative satisfaction measures, (f) performance contracts with and reviews of state agency staff, (g) audits completed by entities external to the agency, and (h) other oversight activities as appropriate.

D. DEFINITION OF TERMS

1. **Disability.** The technical definition of disability, used for purposes of determination of waiver eligibility, has not changed in the waiver. This waiver amendment, however, assumes an approach to disability that is based on accommodation as opposed to treatment. This interpretation, which is consistent with the Americans with Disabilities Act, accepts that a disability may be accommodated through changes in the individual (typically accomplished through direct training, exposure to new and varied experiences, increased expectations by others, opportunities to interact with positive role models, etc.) and/or through changes in the individual's environment (including use of assistive technology, environmental modifications, augmentative communication strategies, individualized schedules and routines, training of others in ways of interacting with the person, etc.). The waiver encourages the creative and interactive use of a variety of individual and environmental accommodations that reflect the uniqueness of each person.
2. **Need.** Consistent with the philosophies and practices related to consumer self-determination, person-centered supports, and consumer-driven supports, need is defined by the consumer or within the context of the way in which the consumer chooses to live.
3. **Consumer self-determination.** Self-determination is operationally defined through four guiding principles including: (a) freedom to exercise informed choice among available options of services and supports, both traditional and non-traditional, (b) authority to control a defined amount of dollars to purchase only what is needed and valued, (c) support to nurture informal relationships that might augment, if not replace, some purchased services, and (d) responsibility to contribute to the community. This waiver and companion policies and funding structures are designed to allow for the exercise of consumer self-determination within the boundaries of a publicly-funded system.
4. **Support.** Support is used throughout this waiver document as a replacement term for "service" and "program." While services and programs are established for groups of people with some common characteristic, supports are more uniquely suited to the needs and talents of the individual and to specific ways in which the person's disability may be accommodated.
5. **Support coordinator.** The title, support coordinator, is used in the waiver document as a replacement for the older title, case manager. This change is made simply to reflect the fact that consumers of waiver services are people, not cases and staff support them, they do not manage them.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

X Support Coordination serves the purpose of: (a) establishing and maintaining the individual in the support system and the Home and Community-Based Services Waiver in accordance with program requirements and the individual's assessed support needs and (b) coordinating the delivery of quality waiver services. Support coordination is provided to all individuals who receive services in the Home and Community-Based Services Waiver.

Support Coordination assists individuals to: (a) establish Medicaid financial and categorical eligibility, (b) gain access to waiver supports, State Plan services, medical, social, and educational assessments and services, and any other services, regardless of the funding source, (c) develop a personal budget based on the individual support plan, (d) identify the supports necessary to insure the individual's health and safety, (e) write and update personal social history, (f) write, coordinate, integrate, and assure the implementation of the individual's support plan, and (g) ensure a person-centered plan is written and implemented.

Support Coordination also involves activities to: (h) provide ongoing monitoring to assure the provision and quality of the supports identified in the individual's support plan, (i) provide an initial assessment and ongoing reassessment of the individual's level of care determination, (j) review the individual's support plan at such intervals as are specified in appendices D & E of the Waiver Application document, (k) instruct the individual/legal representative/family how to independently obtain access to services and supports, regardless of funding source, and (l) provide discharge planning services up to 90 days immediately prior to the date an individual living in an ICF/MR is admitted to the waiver.

Limitations: All support coordination must be provided by or under the direction of a Qualified Mental Retardation Professional (QMRP).

X Community Living Supports serve the purpose of facilitating independence and promoting community integration by assisting an individual to gain or maintain skills necessary to live as independently as possible in the type of community-based housing arrangement the individual chooses, consistent with the outcome for community living defined in the individual's support plan.

Community Living Supports can include up to 24 hour direct care staff support. Actual type, frequency, and duration of direct care staff support, and other community living supports will be defined in the individual's support plan based on the individual's selected housing arrangement and assessed needs. Supports are available to individuals who live alone, with roommates, or with family. Community Living Supports will include companion services, which consist of non-medical care, supervision, and socialization. Community Living Supports may also include direct support services

which include assistance with meal preparation, eating , bathing, dressing, and/or personal hygiene.

Limitations: Payments for residential supports are not made for room and board, the cost of facility maintenance, or routine upkeep and improvement, other than costs for modifications or adaptations to a facility required to assure the health, safety and accessibility of the individuals who reside there, consistent with the criteria established for the Environmental Accessibility Adaptation waiver service. Community Living Support is not available to children living in their parent/legal guardian's home.

X Personal Assistance provides personal care and non-medical supportive services, specific to the needs of a medically stable, individual with physical disabilities who is capable of directing his/her own care or has a surrogate available to direct the care. Other reasonable and necessary activities which are incidental to the performance of the client-based care may also be furnished as part of this activity. Services will be outlined in the individual support plan and will not duplicate other covered waiver supports. Personal assistance services are provided on a regularly scheduled basis and are available to individuals who live alone or with roommates. Services may be provided in the recipient's place of residence or in settings outside the place of residence.

Limitations: If and when it is determined that the recipient is unable to adequately perform necessary supervisory activities and has no surrogate to direct the care, alternative supports will be arranged by the waiver support coordinator utilizing appropriate agencies. Providers of personal assistance services will not include a recipient's spouse or parents of a minor child. Other family members may provide personal assistance services if and when they meet the provider qualifications.

X Personal Emergency Response Systems serve the purpose of enabling the individual who has the skills to live independently or with minimal support to summon assistance in an emergency.

Personal Emergency Response Systems are electronic devices of a type that allow the individual requiring such a system to rapidly secure assistance in the event of an emergency. The device may be any one of a number of such devices but must be connected to a signal response center that is staffed twenty-four hours a day, seven days a week by trained professionals. Reimbursement shall include the rental or purchase, installation, removal, replacement and/or the repair of the system.

X **Environmental Accessibility Adaptations** serve to enable the individual to effectively function in the home's physical environment.

Adaptations involve equipment and/or physical adaptations to the individual's residence and/or vehicle that are necessary to assure the health, welfare and safety of the individual or enhance the individual's level of independence. The equipment/adaptations are identified in the individual's support plan and the model and type of equipment are specified by a qualified professional. The adaptations may include purchase, installation, and repairs. Such equipment/adaptations may include:

- a. Ramps
- b. Lifts/elevators
 - 1. porch or stair lifts
 - 2. hydraulic, manual or other electronic lifts
- c. Modifications/additions of bathroom facilities
 - 1. roll-in showers
 - 2. sink modifications
 - 3. bathtub modifications/grab bars
 - 4. toilet modifications/grab bars
 - 5. water faucet controls
 - 6. floor urinal and bidet adaptations and plumbing modifications
 - 7. turnaround space adaptations
- d. Widening of doorways/hallways
- e. Specialized accessibility/safety adaptations/additions
 - 1. door-widening
 - 2. electrical wiring
 - 3. grab bars and handrails
 - 4. automatic door openers/doorbells
 - 5. voice activated, light activated, motion activated and electronic devices
 - 6. fire safety adaptations
 - 7. medically necessary air filtering devices
 - 8. medically necessary heating/cooling adaptations
- f. Vehicle adaptations
 - 1. lifts
 - 2. door modifications
 - 3. steering/braking/accelerating/shifting modifications
 - 4. seating modifications
 - 5. safety/security modifications
- g. Trained and certified canine assistance
 - 1. purchase of trained canine
 - 2. training for recipient and canine
 - 3. animal upkeep (dog food, license, tax, supplies)
 - 4. emergency and preventative Veterinarian services

Other adaptation and repairs may be approved on a case by case basis as technology

changes or as an individual's physical or environmental needs change.

Limitations: Each environmental adaptation must be: 1) documented as medically necessary by a physician; 2) prior approved by DSPD in accordance with written policy including defined qualifying criteria; and 3) documented as not otherwise available as a Medicaid State Plan service. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual. General household repairs are not included but repairs to housing modifications will be allowed, as necessary, if identified in the individual's support plan. Each year of the waiver, dependent on the amount of money allocated by the State Legislature, the DSPD Administrative Team will set aside a discrete amount to be used for this service. All services shall be provided in accordance with applicable State or local building codes.

X Chore and Homemaker Supports serve the purpose of maintaining a clean, sanitary and safe living environment in the individual's residence.

Chore and Homemaker Supports consist of heavy household chores such as snow removal, scrubbing floors, carpets, furniture, windows, and walls or moving heavy items of furniture. The service also includes general household activities when the person usually responsible for the general household activities is absent or needs assistance.

X Supported Employment serves the purpose of supporting individuals, based on individual need, to obtain, maintain, or advance in competitive employment in integrated work settings.

Supported Employment can be full or part time and occurs in a work setting where the individual works with individuals without disabilities (not including staff or contracted co-workers paid to support the individual). Supported Employment may occur anytime during a twenty-four hour day and supports are made available in such a way as to assist the individual to achieve competitive employment (compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals who are not disabled). Individuals in Supported Employment are supported and employed consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individual as indicated in the individual's support plan. An individual may be supported individually or in a group. When appropriate, the agency providing Supported Employment may contract with a co-worker to provide additional support, under the direction of a job coach, as a natural extension of the work day.

Limitations: Payment will only be made for adaptations, supervision and training required by an individual as a result of the individual's disability and will not include payment for the supervisory activities rendered as a normal part of the business setting. Documentation will be maintained that supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of

1973, or the Individuals with Disabilities Education Act. Federal Financial Participation will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses, such as incentive payments made to an employer or beneficiaries to encourage or subsidize an employer's participation in a supported employment program, payments that are passed through to a beneficiary of Supported Employment programs, or for payments for vocational training that is not directly related to a beneficiary's Supported Employment program.

X Site and Nonsite-Based Day Supports serve the purpose of facilitating independence and promoting community inclusion and contribution.

Day Supports provide assistance for individuals to participate in activities in integrated settings with individuals without disabilities (not including staff paid to support the individual). All supports are identified in the individual's support plan and are meaningful activities that contribute to the identified outcomes. Supports may or may not be work related. When applicable, wages are paid in accordance with applicable labor laws. Supports may include instruction in skills an individual wishes to acquire, retain, or improve that enhance the individual's independence, and/or maintain the individual's physical and mental skills. Day supports may be provided anytime during a 24 hour day at locations of the individual's preference and are most commonly provided in integrated community settings.

X Senior Supports are provided to older individuals, or individuals who because of medical problems or physical disabilities have needs that closely resemble those of an older person, who desire a lifestyle consistent with that of the community's population of similar age or circumstances. These supports serve the purpose of facilitating community inclusion and preventing social isolation.

Senior Supports consist of a variety of activities that are designed to assist the individual in maintaining skills and stimulating social interactions with others. The activities are individualized and may occur in any community setting, including the individual's place of residence, in accordance with the individual's stated choice and the objectives of the individual's support plan relating to community integration and prevention of social isolation.

X Transportation Supports serve the purpose of allowing the individual access to other waiver supports necessary to live an inclusive community life.

Transportation Supports are only provided as independent waiver services when transportation is not otherwise available as an element of another waiver service. The need for transportation must be documented as necessary to fulfill other identified supports in the individual support plan and the associated outcomes.

Limitations: Medicaid payment for transportation under the approved waiver plan is not available through medical transportation, transportation available thru the State plan, transportation that is available at no charge, or as part of administrative expenditures.

Additional transportation supports will not be available to residential or day support providers contracted to provide transportation to and from the person's residence to the site(s) of a day support when payment for transportation is included in the established rate paid to the community living or day support provider.

- X Latch Key Supports** serve the purpose of providing supervision for individuals who are not receiving community living supports and whose parents or family are working.

Latch key Supports may be provided before or after the school or work day.

Limitations: Latch Key supports are not available if any other education, day-care, or support programs are available. This service will not be available to more than 25 individuals per-year during the duration of this waiver.

- X Family Assistance and Support (Family Support)** serves the purpose of enabling the family member with a disability, who so desires, to remain in and be supported in the family home. Family Supports are intended to support both the family member with a disability and the rest of the family to live as much like other families as possible with the intent of preventing or delaying unwanted out of home placement.

Family Assistance and Support can be provided either in or out of the home to an individual and his/her family. These supports may include provisions to accommodate the individual's disability in accessing supports offered in the community, providing instructions, and supervision and training to the family/care giver/individual in all areas of daily living. The supports may also include other activities that are identified in the individual's support plan as necessary for continued skill development. Skill development supports may include: (a) developing interventions to cope with problems or unique situations that may occur within the complexity of the family, (b) techniques of behavior supports, (c) enrollment in special summer programs, (d) social skills development, (e) appropriate leisure time activities, and (f) instruction and consultation for the individual with disabilities, the parent and/or the siblings.

All waiver services available to individuals living in a community living arrangement are available to individuals remaining in and receiving waiver services in the family home.

Families may receive services through a provider who has a contract with the State to provide family support services or they may choose the "family choice model" in which the family hires and trains the individuals to provide the supports. In the family choice model, the family may use individuals age 16 and older as direct providers of support. The family choice model requires the family to use an Intermediary Service Organization (ISO) to assist them with managing the financial business and paperwork associated with the family choice model.

Limitations: Family Assistance and Support is available to individuals under age 22.

Comparable services are available to individuals over 22 through community living supports.

X Respite Care Supports serve the purpose of providing coverage and/or relief, on a short-term basis, for those persons who normally provide care in a home setting to an individual who is unable to care for himself or herself.

Respite Care Supports includes day and overnight supports and may be provided in the following locations:

- X** Individual's home or place of residence
- X** Facility approved by the State which is not a private residence.
- X** Temporary care facilities and overnight camps which meet the standards set by DSPD for the temporary care of people with special needs.
- X** Other: As specified in the individual's support plan, in the community, which may include the private residence of the individual providing respite care, in which case the individual will meet the standards prescribed by the Medicaid enrolled respite care agency or DSPD Regional Office with whom they contract. In no case will more than four individuals be served by the provider at any time, including the provider's own minor children who require supervision.

Limitations: The provision of respite care in terms of duration and location will be based on the annual amount allocated by the DSPD Region to the individual/family and the individual/family's preference. Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not the person's private residence.

X Self-Directed Supports serve the purpose of enhancing the individual's ability to exercise his/her rights as a member of society through self-sufficiency and utilization of decision-making authority.

Self Directed Supports involve: (a) consumer and family training and education in self-determination and self-advocacy, (b) competency evaluation and guardianship assistance, (c) advocacy support, (d) identifying, building, and maintaining natural supports, (e) assisting an individual/family/legal representative to obtain services to assess the individual's functional capability to give informed consent in all areas of decision making, (f) instruct and/or consult with families on ways to help their family member with a disability learn the specific skills necessary to become as self-sufficient as possible, (g) instruct and/or consult with families on ways to help their family member with a disability learn the specific skills necessary to safely live in the home setting.

X Educational Supports serve the purpose of providing individualized educational opportunities which are unavailable to the individual through other formal Education programs.

Educational Supports consist of specialized education, individual tutoring, individual

instructions and registration fees for generic education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by the Individuals with Disabilities Education Act.

Limitations: Educational Supports cannot be provided to an individual unless there is a compelling and accepted reason and sufficient documentation that the service is not available from the Individuals with Disabilities Education Act or The Rehabilitation Act of 1973. Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973.

X Specialized Medical Equipment/Supplies/Assistive Technology serves the purpose of enabling an individual to increase his/her ability to perform activities of daily living or to perceive, control or communicate with the environment.

Specialized Medical Equipment/Supplies/Assistive Technology includes devices, controls, prosthesis, or other appliances, the model and types as recommended by a qualified professional. Mobility support devices, bathing support devices, toileting support devices, feeding support devices, and durable medical equipment are included as are the installation of specialized electric and plumbing systems which are necessary to accommodate medical equipment and supplies. Necessity for such devices are specified in the individual's support plan. Reimbursement shall include the purchase, installation, removal, replacement, and repair of approved equipment, supplies, and adaptations.

Limitations: Expenditures for specialized medical equipment, supplies and assistive devices will be in accordance with Division of Services for People with Disabilities policy and all purchases will comply with State procurement requirements. Each year of the waiver, dependent on the amount of money allocated by the State Legislature, the Division's Leadership Team will set aside a discrete amount to be used for this service. Each item of specialized medical equipment, medical supplies, or assistive technology must be prior approved based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

X Specialized Supports serve the purpose of providing: a) treatment, training, consultation, or other unique services necessary to achieve stated outcomes that are not otherwise achievable through Medicaid State Plan services or other waiver supports, or b) non-traditional approaches to care that are effective in achieving desired outcomes in manner that is cost-effective and responsive to the individual's cultural norms and desired treatment strategies.

Specialized supports may be directed solely to a single area of need or may be designed as a coordinated set of supports to provide a holistic approach to addressing inter-related needs. Specialized supports include:

- a. Chiropractic therapy of a nature, amount, duration, or frequency beyond

- the available Medicaid State Plan optional service;
- b. Acupuncture treatment;
- c. Massage therapy;
- d. Individualized diet management program (based on a recommendation by a physician or registered dietitian not associated with the diet management program);
- e. Communication support;
- f. Counseling to assist siblings to develop skills necessary to effectively cope with the dynamics of a family containing a member with a disability and to positively interact with the family member with a disability through family group dynamics and relationships.

Other individual specialized supports may be approved on a case by case basis when demonstrated by the support coordinator as necessary to prevent institutionalization of the individual and to achieve a specific outcome in the individual support plan.

Limitations: Specialized Supports will not duplicate other supports and services available to the individual, must be cost efficient, and must have demonstrated effectiveness for the intended use. Each individual specialized support or set of coordinated supports must be prior approved based on a determination of medical necessity and a determination that the support is not available as a Medicaid State Plan service. Providers must meet the requirements of state law related to the occupational and professional licensing associated with the specific specialized support and the specific experience and skills required of the specialist to meet the individualized needs of the recipient. Required experience and skills will be defined in the individual support plan.

APPENDIX B-2: PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, Utah Code Annotated (UCA), and Utah Administrative Code (UAC) are referenced by citation. Standards not addressed under uniform State citation are attached. Home and community-based waiver services for individuals with developmental disabilities/mental retardation are covered benefits only when delivered through individual contract with the State Medicaid Agency as evidenced by a signed Medicaid Provider Agreement.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Support Coordination	Individual Medicaid provider contracted to provide Support Coordination services			<p>❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.</p> <p>❷ Qualified Mental Retardation Professional (QMRP) as specified in the job specifications in the Division of Human Resources or <i>an individual who can meet QMRP requirements within one year of DSPD hiring date, and is under the supervision of a QMRP who approves/signs-off all Level of Care and Plan of Care documentation.*</i></p>
<p>*Time spent by technicians (“support coordinator assistants”) who are working under the supervision of a QMRP waiver support coordinator, may also be billed as waiver support coordination services. Technicians may not determine Level of Care or be primarily responsible for the development or implementation of the Plan of Care, but their time spent in activities such as coordination and follow-up with allied agencies and related parties, and assisting with the compilation and review of documentation may be reimbursed when approved and signed off by the supervising QMRP.</p>				
Community Living Supports	Individual Medicaid provider contracted to provide Community	Licensed Residential Treatment Facility or	Certification per: R539-6-7, UAC (3 or less indiv.)	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
	Living supports.	Licensed Residential Support: R501-2 & 3, UAC, R539-6, UAC (4 or more indiv.)	professional parent: R501-7-1, UAC	62A-5-103, UCA. ❷ Must meet all standards for performance and professional training listed in DSPD policy R539-6-3 concerning this support.
Personal Assistance	Individual Medicaid provider contracted to provide Personal Assistance support.			❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ❷ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support. Attendants must be over the age of 18, complete a background check, be able to read, understand and carry out written and verbal messages, write simple notes, have training in First Aid, be oriented and trained in all aspects of the care to be provided, and show competence in all areas of responsibility on an ongoing basis.
Personal Emergency Response System	Individual Medicaid provider contracted to provide Personal Emergency Response System supports.	Current business license	FCC registration of equipment placed in individual's home	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ❷ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support.
Environmental Accessibility Adaptations	Individual Medicaid provider contracted to provide Environmental Accessibility Adaptations.	Current business license/contractors license when appropriate	Certification per R539-8-9, UAC	❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. ❷ Must meet all standards for performance

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
				and professional training listed in DSPD policy concerning R539-6 this support. All purchases must be made in accordance with State procurement requirements.
Chore & Homemaker Supports	Individual Medicaid provider contracted to provide Chore/Homemaker supports.			<p>❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.</p> <p>❷ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support, and be able to follow instructions, be physically able to do chores required, and be at least 16 years of age.</p>
Supported Employment	Individual Medicaid provider contracted to provide Supported Employment supports.		certification per R539-6-7, UAC	<p>❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.</p> <p>❷ Must meet all standards for performance and professional training listed in DSPD policy R539-6-3 & R539-8-3 concerning this support.</p>
Nonsite and Site Based Day Supports	Individual Medicaid provider contracted to provide Nonsite and Site Based Day supports.	Site based: R501-3, UAC R539-6-7, UAC	Non site-based: R539-6-7, UAC	<p>❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.</p> <p>❷ Must meet all standards for performance and professional training listed in DSPD policy R539-6-3 concerning this support.</p>
Senior Day Supports	Individual Medicaid provider contracted to provide Senior Day			❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
	supports.			62A-5-103, UCA. 2 Must meet all standards for performance and professional training listed in DSPD policy R539-6-3 concerning this support.
Transportation	Individual Medicaid provider contracted to provide Transportation supports.	Licensed public transportation carrier or individual with drivers license and registered vehicle, per 53-3-202, UCA and 41-12a-301 through 412, UCA.		1 Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. 2 Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support, and possess a current Utah Drivers License and proof of auto liability insurance in amounts required by state law.
Latch Key Supports	Individual Medicaid provider contracted to provide Latch Key supports.	Licensed child care provider, 62A-2-108, UCA		1 Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. 2 Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support.
Family Assistance and Training	Individual Medicaid provider contracted to provide Family Assistance and Training supports.		Certification per R539-6-7, UAC	1 Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. 2 Must meet all standards for performance and professional training listed in DSPD policy R539-6-4 concerning this support.
Respite Care Supports	Individual Medicaid provider contracted to provide Respite Care supports.	Licensed Child Placement Agency, 62A-4a-602, UCA and Licensed Residential	Or certified program per R539-6-7, UAC	1 Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA. 2 Must meet all standards for performance

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
		Treatment Facility, 62A-2-101-(18) UCA		and professional training listed in DSPD policy R539-6-2 and R539-6-4 concerning this support. <i>Individuals (family choice model) employment/certification standards (see pgs B-21& 22 for checklist).</i>
Specialized Medical Equipment/ Supplies/ Assistive Technology	Individual Medicaid provider contracted to provide Specialized Medical Equipment and Supplies.	Current business license	Certification per R539-8-9 and R539-8-10, UAC	<p>❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.</p> <p>❷ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support</p> <p>All purchases must be made in accordance with State procurement requirements.</p>
Self-Directed Supports	Individual Medicaid provider contracted to provide Self-Directed supports.			<p>❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.</p> <p>❷ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support, and must demonstrate competency in related topical area(s) of:</p> <p>(1) self-determination (2) self-advocacy (3) guardianship, competency determination and informed consent in all areas of decision making (4) natural supports, (5) instruct and/or consult with families/siblings on:</p> <p>a) assisting self sufficiency b) safety</p>

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Educational Support	Individual Medicaid provider contracted to provide Educational supports.			<p>❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.</p> <p>❷ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support.</p>
Specialized Supports	Individual Medicaid provider contracted to provide the specified Specialized support.	<p>Must be licensed by State of Utah to practice specific profession;</p> <p>for counseling: 58-60-103, 107, 205, UCA</p> <p>for chiropractic: 58-73, UCA R156-73, UAC</p> <p>for physical therapy: 58-24a, UCA R156-24a, UAC</p> <p>for occupational therapy: 58-42a, UCA R156-42a, UAC</p> <p>for acupuncture: 58-72, UCA R156-72, UAC</p> <p>for massage therapy: 58-47b, UCA</p>		<p>❶ Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA.</p> <p>❷ Must meet all standards for performance and professional training listed in DSPD policy R539-6 concerning this support.</p> <p>Individuals providing communication support shall have demonstrated ability and knowledge of alternative communication devices and programming, and providing support and training on how to use such devices.</p>

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
		R156-47b, UAC for individualized diet management programs: a current Utah business license		

CERTIFICATION CHECKLIST
RESPIRE PROVIDER CERTIFICATION CHECKLIST
 (For Use With 24 Hour Out-of-Home Respite Provider Sites)

Provider Name: _____
 Residence Name: _____
 Residence Address: _____

Region: _____
 Date: _____
 Surveyor: _____

Provider # _____

PROVIDER REQUIREMENTS:		Yes	No	N/A	Comments
1.	No more than two (2) persons are housed in a single bedroom.				
2.	A minimum of sixty (60) square feet per consumer is provided in a multiple occupant bedroom. Storage space/closets not included.				
3.	All bedroom windows are able to be opened and each one has a screen. Window coverings assure privacy and are in good repair.				
4.	Beds are solidly constructed (no portable beds). Each individual has his/her own bed.				
BATHROOMS					
1.	Bathrooms meet a minimum ratio of one (1) toilet, one (1) lavatory, one (1) tub/shower, for each four (4) individuals.				
2.	Toilets and baths/showers allow for individual privacy unless the persons requires assistance.				
3.	Bathroom mirrors are secured to the walls at convenient heights and other furnishings or equipment necessary to meet the consumers basic hygienic needs is installed appropriately.				
4.	Toilet, lavatory, tub/shower are clean and in working order.				
GENERAL					
1.	Interior and exterior of residence is in good repair. Floors, walls, ceilings are clean and in good repair. Yard is free of hazards and debris.				
2.	Kitchen area is clean and in good repair.				
3.	Stove, Refrigerator, and counters, are clean and in good repair.				
4.	Home has an approved fire extinguisher and working smoke detector.				
5.	Furnishings are sufficient, comfortable, clean and in good repair.				
6.	Coverings are on all electric outlets. Light fixtures are in working order. Extension cords are used appropriately.				
7.	There is adequate Hot and Cold water for consumer's needs.				
8.	Heating system is operative and can maintain at least 68 degrees temperature. Cooling system is operative. Furnace area is clean and not used for storage.				
9.	First Aid Kit / Supplies are available.				
10.	Stairways and handrails are provided, if necessary, and are safely maintained.				
11.	Evacuation Plan for Fire / Natural Disasters is on file in the Provider file.				
12.	Potentially hazardous substances are stored in a safe and secure manner.				
13.	Fire Arms and Ammunition are under lock and key in separate rooms.				

COMMENTS:

STATE: UTAH

B-17 EFFECTIVE DATE: July 1, 2001

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

STATE: UTAH

B-18 EFFECTIVE
DATE: July 1,
2001

APPENDIX B-3: KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

A. KEYS AMENDMENT ASSURANCE

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

B. APPLICABILITY OF KEYS AMENDMENT STANDARDS

Check one:

- ☐ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- ☒ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

STATE: UTAH

B-19 EFFECTIVE
DATE: July 1,
2001

APPENDIX C - ELIGIBILITY AND POST-ELIGIBILITY

APPENDIX C-1: ELIGIBILITY

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. **X** Low income families with children as described in section 1931 of the Social Security Act.
2. **X** SSI recipients (SSI Criteria States and 1634 States).
3. Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. **X** Optional State supplement recipients
5. **X** Optional categorically needy aged and disabled who have income at (Check one):
 - a. **X** 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL which is lower than 100%.
6. **X** The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

STATE: **UTAH**

EFFECTIVE DATE: **July 1, 2001**

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

 X A. Yes B. No

Check one:

- a. X The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or
- b. Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) A special income level equal to:

 300% of the SSI Federal benefit (FBR)

 % of FBR, which is lower than 300% (42 CFR 435.236)

\$ which is lower than 300%

(2) Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4) Medically needy without spenddown in 209(b) States.
(42 CFR 435.330)

(5) Aged and disabled who have income at:

STATE: **UTAH**

EFFECTIVE DATE: **July 1, 2001**

- a. _____ 100% of the FPL
- b. _____% which is lower than 100%.

STATE: UTAH

EFFECTIVE DATE: July 1, 2001

(6) ☐ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. ☒ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. ☐ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

STATE: UTAH

EFFECTIVE DATE: July 1, 2001

Appendix C-2: POST-ELIGIBILITY

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under §1924.

REGULAR POST-ELIGIBILITY RULES--§435.726 and §435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest

STATE: UTAH

EFFECTIVE DATE: July 1, 2001

appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

STATE: UTAH

EFFECTIVE DATE: July 1, 2001

- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--§1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of §1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in §1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the §1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

STATE: UTAH

EFFECTIVE DATE: July 1, 2001

POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. § 435.726 --States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. The following standard included under the State plan (check one):

(1) SSI

(2) Medically needy

(3) The special income level for the institutionalized

(4) The following percent of the Federal poverty level): %

(5) Other (specify):

B. The following dollar amount: \$ *

* If this amount changes, this item will be revised.

C. The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

- A. ☐ SSI standard
- B. ☐ Optional State supplement standard
- C. ☐ Medically needy income standard
- D. ☐ The following dollar amount: \$ _____ *
- * If this amount changes, this item will be revised.
- E. ☐ The following percentage of the following standard that is not greater than the standards above: _____ % of standard.
- F. ☐ The amount is determined using the following formula:
- G. ☐ Not applicable (N/A)

3. Family (check one):

- A. ☐ AFDC need standard
- B. ☐ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

- C. ☐ The following dollar amount: \$ _____ *
- *If this amount changes, this item will be revised.
- D. ☐ The following percentage of the following standard that is not greater than the standards above: _____ % of standard.
- E. ☐ The amount is determined using the following formula:

F. ____ Other

G. ____ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. X The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:

(check one)

- (a) ___ SSI Standard
- (b) ___ Medically Needy Standard
- (c) ___ The special income level for the institutionalized
- (d) ___ The following percent of the Federal poverty level: ___ %
- (e) ___ The following dollar amount: \$ _____ **

**If this amount changes, this item will be revised.

- (f) ___ The following formula is used to determine the needs allowance:

Net income deduction equals 100% of FPL. Earned income deduction equals SSI SGA Level.

- (g) ___ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

Appendix C-3: COORDINATION OF MEDICAID ELIGIBILITY DETERMINATION AND LEVEL OF CARE DETERMINATION

Payment for Home and Community-Based waiver services are not permitted prior to the date the Medicaid applicant has been determined to meet both eligibility for the Medicaid program and the level of care eligibility defined by the Medicaid program for ICF/MR admission. The one exception is in the case of Support Coordination services involving discharge planning services provided to an ICF/MR resident in the 30-day period immediately preceding his or her first day of admission to the waiver.

For purposes of the waiver program, documentation of the two eligibility dates is accomplished through completion of the Form 927, "Home and Community-Based Waiver Referral Form", including signature by both a Medicaid eligibility worker from the State Medicaid Agency or the Department of Workforce Services (as applicable) and a HCBS Waiver Support Coordinator. The Form 927 must specify the effective date of applicant's Medicaid eligibility determination and the effective date of the applicant's level of care eligibility determination and be maintained on file by the appropriate Support Coordinator.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

A. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

B. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

- ☐ Discharge planning team
- ☐ Physician (M.D. or D.O.)
- ☐ Registered Nurse, licensed in the State
- ☐ Licensed Social Worker
- ☒ Qualified Mental Retardation Professional, as defined in Appendix B-2 of this Document or an individual who can meet the requirements defined in Appendix B-2 within one year of hire, and is under the supervision of a Qualified Mental Retardation Professional who must approve and sign-off all level of care and individual support plan decisions and documentation until the supervisee meets the Qualified Mental Retardation Professional qualifications.
- ☐ Other (specify):

The State Medicaid Agency has an interagency agreement authorizing the Division of Services for People with Disabilities to certify the level of care for waiver applicants and recipients. It is the waiver support coordinator in the Division of Services for People with Disabilities who certifies the level of care. However, ultimate responsibility for oversight of the level of care determination process remains with the single state agency and the State Medicaid Agency retains authority to review level of care determinations made by the Division of Services for People with Disabilities and to make necessary modifications to the determinations.

APPENDIX D-2

A. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the recipient will take place (at a minimum) according by the following schedule (specify):

- ☐ Every 3 months
- ☐ Every 6 months
- ☐ Every 12 months
- ☒ Other (specify): Client level of care evaluations must occur at least annually, 12 months from entry into the Home and Community-Based Services waiver program or from the most current level of care evaluation, with completion during the calendar month in which it is due.

B. QUALIFICATIONS OF EVALUATORS PERFORMING REEVALUATIONS

Check one:

- ☒ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.
- ☐ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care. (Specify.)
 - ☐ Physician (M.D. or D.O.)
 - ☐ Registered Nurse, licensed in the State
 - ☐ Licensed Social Worker
 - ☐ Qualified Mental Retardation Professional, as defined in Appendix B1 of this document
 - ☐ Other (specify):

C. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

STATE: UTAH

Δ-2

EFFECTIVE DATE: July 1, 2001

The State will employ the following procedures to ensure timely reevaluations of level of care (check all that apply):

- ☐ "Tickler" file
- ☐ Edits in computer system
- ☒ Component part of support coordination.
- ☐ Other (specify):

APPENDIX D-3

A. MAINTENANCE OF RECORDS

1. Record of evaluations and reevaluations of level of care will be maintained in the following locations (check all that apply):

- ☐ In the Medicaid agency in its central office
- ☐ In the Medicaid agency in district/local offices
- ☒ In the agency designated in Appendix A as having primary authority for the daily operations of the waiver program
- ☒ In the individual's support coordinator's files
- ☒ In the person(s) or agencies designated as responsible for the performance of evaluations and reevaluations
- ☐ By service providers
- ☐ Other (specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this appendix for a minimum period of 5 years.

B. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument, Form 817, used in the evaluation and reevaluation of a recipient's need for a level of care is attached to this Appendix (see pages D-7 and D-8).

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

- ☒ The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.
- ☐ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

C. DOCUMENTATION REQUIRED TO MAKE A LEVEL OF CARE DETERMINATION

The following histories/evaluations are required for determination of level of care:

1. Assessment of functional limitations in the areas of self care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
2. Social History and/or Social Summary - completed by applicant or for the applicant within one year of the date of application.
3. Psychological or Medical Diagnostic Evaluation or a written waiver completed by DSPD Regional staff.
4. Documentation of date of onset of disability.

The qualified support coordinator reviews the individual's developmental, health/medical, social, psychological/psychiatric, and functional levels. Through this process, a diagnosis is formulated and gathered from the physician and/or psychologist, and a level of care determination made. The level of care is certified on the Form 817.

Individuals will be determined eligible for the waiver if the following criteria are met:

1. The individual is Medicaid eligible;
2. The individual's diagnosis of mental retardation/developmental disability is documented by a physician or psychologist's assessment;
3. A qualified waiver support coordinator has documented that the individual meets the level of care requirements specified in R414-502-8: Criteria for Intermediate Care Facility for the Mentally Retarded; and
4. The individual, but for the provision of waiver services would otherwise require placement in an ICF/MR to receive needed services.

D. LEVEL OF CARE EVALUATION QUALITY ASSURANCE

The State Medicaid Agency retains final authority for oversight of the level of care evaluation process as set forth in Section G of the interagency agreement between the State Medicaid Agency and DSPD. The oversight function involves an annual review of the level of care evaluations for a sample of waiver recipients representative of the caseload distribution across the program. If the sampling identifies potential level of care systematic problems, an expanded review is initiated by the State Medicaid Agency.

HOME AND COMMUNITY-BASED SERVICES WAIVER
LEVEL OF CARE
DETERMINATION

Initials:
Date:

Based on formal assessments, the individual must meet **all** requirements in item 1, and **one** requirement in item 2 below, to meet the level of care requirements for placement in an intermediate care facility for mentally retarded.

1. Requires care above level of room and board as documented by **all** of the following criteria (check all that apply).
- ☐ Onset of condition was before age 18 for mental retardation or before age 22 for developmental disabilities.
- ☐ Primary condition is not attributable to mental illness.
- ☐ Requires at least weekly intervention by or under the supervision of a health care professional or trained habilitative personnel.
- ☐ Cannot be maintained in less restrictive environment without Home and Community-Based Waiver services.
2. **Plus one** of the following (check one box):
- ☐ Has mild, moderate, severe, or profound Mental Retardation.

Specify level of Mental Retardation:_____. Code:_____.

- ☐ Has a developmental disability and requires care and services similar to that of an individual with mental retardation.

Specify developmental disability:_____. Code:_____.

I hereby certify that but for the provision of Home and Community-Based Waiver services the individual would require the level of care provided in an intermediate care facility for mentally retarded.

Qualified Mental Retardation Professional:_____. Date:_____.

Choice of Service: I have been advised that I may choose either Home and Community-Based Waiver services or an intermediate care facility for mentally retarded. I have been informed of alternatives available under the Waiver and I choose:

☐ Home and Community-Based Waiver services. ☐ Intermediate care facility for mentally retarded.

Individual's and/or Legal Representative's Signature:_____. Date:_____.

Annual Reviews: I hereby certify that the individual's condition and diagnosis have not changed; therefore, there is a demonstrated need for continuing services under the Home and Community-Based Waiver.

Qualified Mental Retardation Professional:_____. Date:_____.

Qualified Mental Retardation Professional:_____. Date:_____.

Qualified Mental Retardation Professional:_____. Date:_____.

Qualified Mental Retardation Professional:_____. Date:_____.

STATE: UTAH

Δ-7 EFFECTIVE DATE: July 1, 2003

INSTRUCTIONS FOR THE FORM 817

PURPOSE:

The form 817 is an eligibility form used for data entry and documenting an individual's diagnosis and eligibility for Home and Community-Based Waiver Services.

COMPLETING THE FORM:

Individual's Name: The name under which the individual is open on State data-base. **Individual's Data Entry Number:** The individual identification number from the State data-base.

Level of Care Documentation: This section documents the individual's eligibility for an intermediate care facility for mentally retarded and Home and Community-Based Waiver services. Check the appropriate boxes.

Information regarding the individual's developmental disability and/or level of mental retardation should be obtained from assessment documents (medical and psychological reports) and written in the spaces provided along with the appropriate code from the International Classification of Diseases. Listed below are the levels of mental retardation and the most common developmental disabilities:

Codes from the International Classification of Diseases, 9th Edition (look up additional codes in the book itself):

Mild Mental Retardation-	3170
Moderate Mental Retardation-	3180
Severe Mental Retardation-	3181
Profound Mental Retardation-	3182
Epilepsy-	3450
Cerebral Palsy-	3430
Autism-	2990

Signature Area: Initial signature must be on or before the date that the client enters Home and Community-Based Waiver services. The region staff completing the document must be a Qualified Mental Retardation Professional or the document must be reviewed and co-signed by a supervisor who is a Qualified Mental Retardation Professional.

Choice of Service: Indicate that the individual and/or their legal representative have been advised of their right to choose between Home and Community-Based Waiver services and an intermediate care facility for mentally retarded by checking the service chosen and having the individual and/or their legal representative sign in the space provided.

Annual Reviews: Annually, the Qualified Mental Retardation Professional must review the individual's diagnostic information and eligibility for Home and Community-Based Waiver services. If the diagnostic information or level of care information changes, a new form 817 must be completed. If the diagnostic information or level of care remains the same, the professional signs and dates.

DISPOSITION OF FORM:

Once completed, the individual's level of mental retardation code and/or their developmental disability code must be entered into the State data-base for payment to occur.

Placement in the individual's file: File in Eligibility section.

APPENDIX D-4

A. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require the level of care specified for this request, the person or the person's legal representative will be:
 - a. informed of any feasible alternatives under the waiver; and
 - b. given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care specified for this request, or who are denied the waiver service(s) of their choice or the waiver provider(s) of their choice.
3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice;
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
 - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

B. FREEDOM OF CHOICE DOCUMENTATION

Freedom of choice is documented on the Form 817 (page D-7) and is maintained in the individual's support coordinator's file. This form describes the agency's procedure(s) for informing an eligible individual or the individual's legal representative of the feasible alternatives available under the waiver and allowing individuals to choose either institutional or home and community-based services.

Freedom of choice procedures

1. When an individual is determined eligible for waiver services, the individual and the individual's legal representative will be informed of the alternatives available under the waiver and offered the choice of institutional care (ICF/MR) or home and community-based care. A copy of the DSPD publication *A GUIDE TO SERVICES FOR PEOPLE WITH DISABILITIES* (hereafter referred to as the Guide), which describes the array of services and supports available in Utah including ICFs/MR and the HCBS Waiver program, is given to each individual making application for waiver services.
2. The support coordinator will offer the choice of waiver services only if:
 - a. The individual's needs assessment indicates the supports the individual requires, including waiver supports, are available in the community.
 - b. The support plan has been agreed to by all parties.
 - c. The health and safety of the individual can be adequately protected in relation to the delivery of waiver services and supports.
3. If waiver services are chosen, the individual and the individual's legal representative will be given the opportunity to choose the providers of waived services if more than one qualified provider is available to render the services. The individual's choice of services and providers will be documented in the individual's support plan.
4. Once the individual has chosen home and community-based waiver services, the choice has been documented by the support coordinator, and the individual has received a copy of the Guide, annual review of choice will not be required. It is, however, the individual's option to choose institutional (ICF/MR) care at any time during the period they are in the waiver.

C. RIGHTS TO A FAIR HEARING DOCUMENTATION

1. DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

An individual and the individual's legal representative will receive a written Notice of Agency Action from the waiver support coordinator if the individual is found ineligible for, denied access to, or experiences a reduction in waiver services. The Notice of Agency Action delineates the individual's right to appeal the decision. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing (Form 490S) and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination. A copy of the Form 490S, Hearing Rights, is attached to this Appendix (see page D-12).

2. SINGLE STATE AGENCY

The State Medicaid Agency provides individuals receiving waiver services an opportunity for a hearing upon written request (see C.1. above), if they are:

1. not given the choice of institutional (ICF/MR) care or community-based (waiver) services;
2. denied the waiver services of their choice; or
3. denied the waiver provider(s) of their choice if more than one provider is available to render the service(s).

It is the policy and preference of the single State agency to resolve disputes at the lowest level through open discussion and negotiation between the involved parties.

HEARING RIGHTS

If you or your legal guardian disagree with any decision, service, or action of the Division of Services for People with Disabilities (Division), you have the right to receive a formal hearing at anytime prior to, during or immediately following the 3 step Division resolution process outlined below. The Division staff will begin the Division resolution process or send your request directly to the appropriate agency for a formal hearing (according to your directions) once your completed Hearing Request form 490S is received at the address listed below.

- Step 1 The Division staff explains the regulations on which the action is based and attempts to resolve the disagreement.
- Step 2 If resolution of the problem is unsuccessful, the Division staff arranges a region review meeting between you and your legal representative, if any, and the region supervisor and/or region director.
- Step 3 If a region review does not resolve the issue, Division staff arrange a Division review meeting between you and your legal representative, if any, the Division director and region director.

At anytime during the Division resolution process you may request that the original form 490s and other required documentation be forwarded to the appropriate hearing office, for a formal hearing before that Department's Hearing Examiner. **You must make your request for resolution and/or a hearing within 30 days of the postmark of this notice. This letter represents such a Division decision or action. If you wish to continue to receive services during the resolution of the concern, you must request resolution within 10 days of the postmark of this notice.** You, your parents, and/or your legal guardian have the right to be represented and/or be accompanied by other individuals at the Division review meetings and the Department hearing. You may be eligible for legal help without charge. Your support coordinator at the Division may suggest where free legal help may be available. It should be noted, that your attorney represents you but does not necessarily represent your parents or legal representative.

To begin the resolution process fill in and sign the bottom half of this sheet. Tear it off and mail it to:

**PLACE NAME OF REGION DESIGNEE
AND
REGION ADDRESS HERE**

Select A or B: ☐ (A). I want Division resolution ☐ (B). I want a formal hearing
I would like services to continue during the resolution/hearing process ☐ Yes ☐ No
If "yes" this request for a resolution/hearing is being made within 10 days of postmark of this notice
I am requesting a resolution/hearing because

Please Print the Following:

Name:	Street Address	Date
Social Security Number	City, State, Zip	Telephone
Signature of Person and/or Representative		

APPENDIX D-5

REVIEW PROTOCOLS FOR WAIVER DISENROLLMENT

The Division of Health Care Financing (DHCF) in partnership with the Division of Services for People with Disabilities (DSPD) will compile information on voluntary disenrollments, and routine involuntary disenrollments and will conduct reviews of proposed special circumstance disenrollments from the waiver.

1. Voluntary disenrollments are cases in which clients choose to initiate disenrollment from the waiver. These cases require written notification to the Division of Health Care Financing by the Division of Services for People with Disabilities within 30 days from date of disenrollment. Documentation will be maintained by the Division of Services for People with Disabilities detailing the discharge planning activities completed with the waiver enrollee as part of the disenrollment process.
2. Pre-Approved involuntary disenrollments are cases in which clients are involuntarily disenrolled from a home and community based waiver program for any one or more of the specific reasons listed below:
 - a. Client death;
 - b. Client no longer meets financial requirement for Medicaid program eligibility;
 - c. Client has moved out of the State of Utah; or
 - d. Client whereabouts are unknown.
3. Pre-Approved involuntary disenrollments require written notification to the Division of Health Care Financing by the Division of Services for People with Disabilities within 30 days from date of disenrollment. No Division of Health Care Financing prior review or approval of the decision to disenroll is required. Documentation will be maintained by the Division of Services for People with Disabilities detailing the discharge planning activities completed with the waiver enrollee as part of the disenrollment process. Notification shall be provided to the Division of Health Care Financing within 30 days after discharge. Documentation will be maintained by the program, detailing the discharge planning activities completed with the client as part of the disenrollment process.

4. Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the individual involved. Examples of this type of disenrollment include the waiver client no longer meets the corresponding institutional level of care requirements, the client's health and safety needs cannot be met by the current program's services and supports, or the client has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a plan of care that meets minimal safety standards.
5. Special circumstance disenrollments require review and authorization prior to disenrollment to facilitate:
 - a. Appropriate movement amongst programs;
 - b. Effective utilization of program potential;
 - c. Effective discharge and transition planning;
 - d. Provision of information, affording clients the opportunity to exercise all rights; and
 - e. Program quality assurance/quality improvement measures.
6. The special circumstance disenrollment review process will consist of the following activities:
 - g. The waiver case management agency recommending disenrollment will compile information to articulate the disenrollment rationale.
 - h. The waiver case management agency will then submit the information to the state-level program management staff for their review of the documentation of case management activities and of the disenrollment recommendation.
 - i. If state-level program management staff concur with the case management recommendation, the case will be forwarded to the DHCF for a final decision.
 - j. The DHCF will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.
 - k. The DHCF will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.

1. The DHCF final disenrollment decision will be communicated to both the case management agency and the state-level program management staff in writing.
7. If the disenrollment is approved, the waiver case management agency will provide to the individual the required written notification of agency action and right to fair hearing information.
8. The case management agency will initiate discharge planning activities sufficient to assure smooth transition to an alternate Medicaid program or to other services.

APPENDIX E - SUPPORT PLAN

APPENDIX E-1

SUPPORT PLAN DEVELOPMENT

1. The following individuals are responsible for the preparation of the individual support plans:

_____ Registered nurse, licensed to practice in the State

_____ Licensed practical or Vocational nurse, acting within the scope of practice under State law

_____ Physician (M.D. or D.O.) licensed to practice in the State

_____ Social Worker (qualifications attached to this Appendix)

X Support Coordinator

_____ Other (specify):

2. Copies of written support plans will be maintained for a minimum period of 3 years. Specify each location where copies of the support plans will be maintained.

_____ At the Medicaid agency central office

_____ At the Medicaid agency county/regional offices

X By support coordinators

_____ By the agency specified in Appendix A

_____ Other (specify):

3. The support plan is the fundamental tool by which the State will ensure the health and welfare of the recipients. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the recipient's disability. The minimum schedule under which these reviews will occur is:

_____ Every 3 months

_____ Every 6 months

_____ Every 12 months

X Other (specify): The support plan should be reviewed as frequently as necessary, with a formal review at least annually, completed during the calendar month in which it is due.

APPENDIX E-2

A. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the support plan is made subject to the approval of the Medicaid agency:

1. A written support plan is developed for each individual who receives Home and Community-Based waiver supports. The support plan describes the type, amount, frequency and duration of services to be furnished and the type of provider who will furnish them. The support plan is developed by the support coordinator in consultation with the individual, the individual's legal representative and others as necessary and appropriate. The support plan constitutes a plan for services, supports and life activities to meet the needs of the individual and prevent institutionalization.
2. The DSPD State Office, through an interagency agreement with the State Medicaid Agency, is delegated first level responsibility to review and approve written support plans as part of its state monitoring responsibility.
3. The State Medicaid Agency retains final authority for oversight and approval of the support planning process as set forth in Section G of the interagency agreement between the State Medicaid Agency and DSPD. The oversight function involves an annual review of a sample of waiver recipient's support plans that is representative of the caseload distribution across the program. If the sampling identifies potential support planning systematic problems, an expanded review is initiated by the State Medicaid Agency.

B. STATUTORY REQUIREMENTS AND COPY OF SUPPORT PLAN

1. The support plan will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. Additional mandatory support plan content elements are:
 - a. Effective date;
 - b. Name of individual receiving waiver services;
 - c. Address;
 - d. Support Coordinator's name and office location;

- e. List of all waiver supports to be provided to the individual, including support coordination when applicable, and all other services needed by the individual, regardless of funding source;
- f. Documentation of individual's choice of waiver providers and that the individual was advised of hearing rights, if not provided choice;
- g. Documentation that individual was informed of rights in accordance with Division of Services for People with Disabilities policies per R539-2-1 and R539-2-5 and rights to hearing;
- h. Expected start date, amount, frequency and duration of each support;
- i. The type of provider who will furnish each support;
- j. Required experience and skills of individual providers of specified Specialized Support(s);
- k. Signatures of individual receiving supports, individual's Support Coordinator, and the individual's legal representative (when applicable);
- l. Documentation of the individual's choice of waiver services and waiver providers.

C. SUPPORT COORDINATION ENCOUNTERS

To better focus primary attention on providing the specific level of case management/support coordination intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the individual service plan will be the vehicle through which the level of assessed need for case management/support coordination will be detailed in terms of the objectives to be achieved, and the scope, duration, and frequency of intervention to be provided to meet the stated objectives. This approach will also promote case managers/support coordinators having specific information about their expected roles and responsibilities on an individualized waiver client basis. Program performance reviews will assess the accuracy and effectiveness of the link between the determination of need, the service plan, the implementation of case management/support coordination services, and the ongoing evaluation of progress toward the stated objectives.

APPENDIX F - AUDIT TRAIL

A. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):
 - ☒ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS)*.
 - ☐ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.
 - ☐ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payment are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.
 - ☐ Other (Describe in detail):

* A letter dated November 27, 1987 from Candido Salazar, Jr. representing HCFA, approves the Utah Department of Human Services, Utah Social Services Database System as an extension of the Utah Department of Health's MMIS. Claims are prepared and processed through the Utah Social Services Database System data base for submission to the Department of Health's MMIS. Under the terms of the November 1987 agreement with HCFA, the Utah Department of Human Services processes up-front claims for waiver services and creates an electronic tape, with claims data presented in the approved HCFA 1500 format. The data collected is entered into the MMIS for proper updating of the recipient and provider files. The Utah Department of Human Services ensures that all

input is captured at the earliest possible time and in an accurate manner. The MMIS adjudicates the waiver claims and reimburses the Utah Department of Human Services the necessary funds to cover any legitimate interim payments made to service providers.

A copy of the November 27, 1987 letter from Mr. Salazar is on file at the offices of the State Medicaid Agency.

B. BILLING PROCESS AND RECORDS RETENTION

1. Following on pages F-4 and F-5 is a description of the billing process used for this waiver. Included is a description of the mechanism in place to assure that all claims for payment of waiver services are made only:
 - a. When the client was eligible for Medicaid waiver payment on the date of service;
 - b. When the service was included in the approved support plan;
 - c. In the case of supported employment or education services included as part of support services, when the client was eligible to receive the services, and the services are not available to the client through a program funded under section(s)(15) and (17) of the Individuals with Disabilities Education Act (IDEA) or section 110 of the Rehabilitation Act of 1973.

 X yes.

 no. These services are not included in the waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

 X All claims are processed through an approved MMIS.

 MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A, and providers of waiver services for a minimum period of 3 years.

DESCRIPTION OF BILLING PROCESS AND RECORDS RETENTION

1. A client's Medicaid eligibility is determined by the Office of Health and Eligibility within the Department of Workforce Services. The information is entered into the Public Assistance Case Management Information System (PACMIS). PACMIS is an on-line, menu-driven system which automates Medicaid eligibility decisions, benefits amounts, client notices and administrative reports. PACMIS interfaces with other governmental agencies such as, Social Security, Employment Security, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through PACMIS: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Utah Medical Assistance Program (UMAP). The Medicaid Management Information System (MMIS) accesses PACMIS to ensure the client is Medicaid eligible before payment of claims is made.
2. Post-payment reviews are conducted in accordance with the procedures outlined in Appendix E-2. The Medicaid agency reviews a sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan .
3. Prior to the delivery of Medicaid reimbursed supported employment services, the Division of Rehabilitation Services (DRS) must document the individual's ineligibility for DRS services funded under section 110 of the Rehabilitation Act. The support coordinator will obtain written documentation (FORM 58) of the DRS determination prior to authorizing reimbursement for supported employment services under the waiver.

Prior to the delivery of Medicaid reimbursed educational services, the waiver support coordinator must obtain written documentation that the services are not available to the individual through a program funded under section(s) (16) or (17) of the Individuals with Disabilities Education Act (IDEA) The support coordinator will obtain such documentation prior to authorizing Medicaid reimbursement for educational services under the waiver. (This requirement does not pertain to individuals over the age of 22 who are receiving educational services under the waiver.)

4. Prior to the order and completion of Medicaid reimbursed environmental adaptations, the support coordinator must obtain prior approval based on a determination of medical necessity and a determination that the adaptation is not available as a Medicaid State Plan service.
5. Prior to the order and delivery of Medicaid reimbursed approved specialized medical equipment, medical supplies, or assistive technology, the support coordinator must obtain prior approved based on a determination of medical necessity and a determination that the item is not available as a Medicaid State Plan service.

C. PAYMENT ARRANGEMENTS

1. Check all that apply:

- X** The Division of Services for People with Disabilities will make payments directly to providers on behalf of the Medicaid agency as previously described in Appendix F, items A and B.
- The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.
- The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.
- Providers may voluntarily reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. The interagency agreement reflecting the above arrangements are on file at the State Medicaid Agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1: COMPOSITE OVERVIEW COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	<u>\$22,863</u>	<u>\$7,049</u>	<u>\$58,240</u>	<u>\$3,072</u>
2	<u>\$22,191</u>	<u>\$7,296</u>	<u>\$60,278</u>	<u>\$3,180</u>
3	<u>\$24,119</u>	<u>\$7,551</u>	<u>\$62,388</u>	<u>\$3,290</u>
4	<u>\$26,148</u>	<u>\$7,815</u>	<u>\$64,571</u>	<u>\$3,406</u>
5	<u>\$28,281</u>	<u>\$8,088</u>	<u>\$66,831</u>	<u>\$3,525</u>

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

<u>YEAR</u>	<u>UNDUPLICATED INDIVIDUALS</u>
1	3355
2	3822
3	3822
4	3822
5	3822

EXPLANATION OF FACTOR C:

Check one:

_____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

X The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State Legislature for that time period.

The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

APPENDIX G-2: METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: **ICF/MR**

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1 X 2 3 4 5

Waiver Service Column A	Type of Unit	# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	TOTAL Column E
SUPPORT COORDINATION	monthly	3,355	12	\$202.57	\$8,155,468.00
SELF-DIRECTED SUPPORTS	hourly	500	48	\$21.20	\$508,800.00
COMMUNITY LIVING SUPPORTS	daily	1,216	303	\$119.17	\$43,907,948.00
COMMUNITY LIVING SUPPORTS	hourly	319	323	\$11.52	\$1,186,986.00
COMMUNITY LIVING SUPPORTS	hourly	250	498	\$20.19	\$2,513,655.00
CHORE/HOMEMAKER SUPPORTS	hourly	100	24	\$14.58	\$34,992.00
SUPPORTED EMPLOYMENT	hourly	330	170	\$30.31	\$1,700,391.00
SUPPORTED EMPLOYMENT	daily	220	170	\$31.15	\$1,165,010.00
NONSITE BASED DAY SUPPORTS	hourly	60	170	\$29.67	\$302,634.00
SITE BASED DAY SUPPORTS	daily	1,220	160	\$48.07	\$9,383,264.00
SENIOR DAY SUPPORTS	daily	100	160	\$48.07	\$769,120.00
EDUCATIONAL SUPPORTS	hourly	10	12	\$15.30	\$1,836.00
EDUCATIONAL SUPPORTS	need	10	1	\$1,060.00	\$10,600.00
FAMILY ASSISTANCE AND SUPPORT	hourly	633	200	\$16.53	\$2,092,698.00
RESPIRE CARE	hourly	603	150	\$10.60	\$958,770.00
RESPIRE CARE	daily	525	20	\$58.79	\$617,295.00
LATCH KEY SUPPORTS	hourly	25	480	\$7.42	\$89,040.00
TRANSPORTATION SUPPORT - TAXI	mileage	150	240	\$1.59	\$57,240.00
TRANSPORTATION SUPPORT - PRIV.	mileage	500	600	\$0.32	\$96,000.00
TRANSPORTATION SUPPORT	daily	1,051	180	\$7.72	\$1,459,080.00
TRANSPORTATION SUPPORT	bus pass	100	12	\$25.44	\$30,528.00

STATE: UTAH

Γ-4

EFFECTIVE DATE: July 1, 2001

ENVIRONMENTAL ADAPTATIONS	need	100	1	\$1,427.00	\$142,700.00
SPECIALIZED MED EQUIP/SUPPLIES	monthly	100	12	\$265.00	\$318,000.00
SPECIALIZED MED EQUIP/SUPPLIES	need	100	1	\$1,331.00	\$133,100.00
PERS EMERGENCY RESPONSE SYS	one-time	100	1	\$297.00	\$29,700.00
PERS EMERGENCY RESPONSE SYS	monthly	200	9	\$40.27	\$72,486.00
SPECIALIZED SUPPORTS - CHIROP.	hourly	150	6	\$42.40	\$38,160.00
SPECIALIZED SUPPORTS - ACCUP.	hourly	40	6	\$53.70	\$12,888.00
SPECIALIZED SUPPORTS - MASSAGE	hourly	150	12	\$42.40	\$76,320.00
SPECIALIZED SUPPORTS - DIET	monthly	60	12	\$39.92	\$28,742.00
SPECIALIZED SUPPORTS - COMM.	hourly	75	8	\$36.00	\$21,600.00
SPECIALIZED SUPPORTS - COUNSEL	hourly	25	12	\$63.60	\$19,080.00
PERSONAL ASSISTANCE	monthly	90	12	\$635.90	\$686,772.00
PERSONAL ASSISTANCE	hourly	50	170	\$10.13	\$86,105.00
GRAND TOTAL (sum of Column E):					\$76,707,008.00
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					3,355
FACTOR D (Divide total by number of recipients):					\$22,863
AVERAGE LENGTH OF STAY: <u>340 Days</u>					

APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1 ____ 2 X 3 ____ 4 ____ 5

Waiver Service Column A	Type of Unit	# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	TOTAL Column E
SUPPORT COORDINATION	monthly	3,822	12	\$209.65	\$9,615,387.60
SELF-DIRECTED SUPPORTS	hourly	530	48	\$22.58	\$574,435.20
COMMUNITY LIVING SUPPORTS	daily	1,287	303	\$123.34	\$48,097,789.74
COMMUNITY LIVING SUPPORTS	hourly	338	323	\$11.92	\$1,301,354.08
COMMUNITY LIVING SUPPORTS	hourly	267	498	\$20.90	\$2,778,989.40
CHORE/HOMEMAKER SUPPORTS	hourly	107	24	\$15.09	\$38,751.12
SUPPORTED EMPLOYMENT	hourly	348	170	\$31.37	\$1,855,849.20
SUPPORTED EMPLOYMENT	daily	235	170	\$32.24	\$1,287,988.00
NONSITE BASED DAY SUPPORTS	hourly	64	170	\$30.70	\$334,016.00
SITE BASED DAY SUPPORTS	daily	1,294	160	\$49.75	\$10,300,240.00
SENIOR DAY SUPPORTS	daily	107	160	\$49.75	\$851,720.00
EDUCATIONAL SUPPORTS	hourly	11	12	\$15.83	\$2,089.56
EDUCATIONAL SUPPORTS	need	11	1	\$1,097.10	\$12,068.10
FAMILY ASSISTANCE AND SUPPORT	hourly	672	200	\$17.11	\$2,299,584.00
RESPIRE CARE	hourly	640	150	\$10.97	\$1,053,120.00
RESPIRE CARE	daily	554	20	\$60.84	\$674,107.20
LATCH KEY SUPPORTS	hourly	25	480	\$7.68	\$92,160.00
TRANSPORTATION SUPPORT - TAXI	mileage	160	240	\$1.65	\$63,360.00
TRANSPORTATION SUPPORT - PRIV.	mileage	530	600	\$0.33	\$104,940.00
TRANSPORTATION SUPPORT	daily	1,113	180	\$8.00	\$1,602,720.00
TRANSPORTATION SUPPORT	bus pass	107	12	\$26.33	\$33,807.72

STATE: UTAH

Γ-6 EFFECTIVE DATE: January 1, 2002

ENVIRONMENTAL ADAPTATIONS	need	107	1	\$1,476.95	\$158,033.65
SPECIALIZED MED EQUIP/SUPPLIES	monthly	107	12	\$274.28	\$352,175.52
SPECIALIZED MED EQUIP/SUPPLIES	need	107	1	\$1,377.58	\$147,401.06
PERS EMERGENCY RESPONSE SYS	one-time	107	1	\$307.40	\$32,891.80
PERS EMERGENCY RESPONSE SYS	monthly	214	9	\$41.68	\$80,275.68
SPECIALIZED SUPPORTS - CHIROP.	hourly	160	6	\$43.88	\$42,124.80
SPECIALIZED SUPPORTS - ACCUP.	hourly	43	6	\$55.57	\$14,337.06
SPECIALIZED SUPPORTS - MASSAGE	hourly	160	12	\$43.88	\$84,249.60
SPECIALIZED SUPPORTS - DIET	monthly	64	12	\$41.32	\$31,733.76
SPECIALIZED SUPPORTS - COMM.	hourly	78	8	\$37.26	\$23,250.24
SPECIALIZED SUPPORTS - COUNSEL	hourly	25	12	\$65.83	\$19,749.00
PERSONAL ASSISTANCE	monthly	96	12	\$658.16	\$758,200.32
PERSONAL ASSISTANCE	hourly	53	170	\$10.48	\$94,424.80
GRAND TOTAL (sum of Column E):					\$84,813,324.21
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					3,822
FACTOR D (Divide total by number of recipients):					\$22,191
AVERAGE LENGTH OF STAY: <u>340 Days</u>					

STATE: UTAH

Γ-7

EFFECTIVE DATE: January 1, 2002

APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1 ____ 2 ____ 3 X 4 ____ 5

Waiver Service	Type of Unit	# Undup. Recip. (Users)	Avg. # Annual Units/User	Avg. Unit Cost	TOTAL
Column A		Column B	Column C	Column D	Column E
SUPPORT COORDINATION	monthly	3,822	12	\$217.00	\$9,952,488.00
SELF-DIRECTED SUPPORTS	hourly	560	48	\$23.37	\$628,185.60
COMMUNITY LIVING SUPPORTS	daily	1,360	303	\$127.65	\$52,602,012.00
COMMUNITY LIVING SUPPORTS	hourly	357	323	\$12.34	\$1,422,937.74
COMMUNITY LIVING SUPPORTS	hourly	282	498	\$21.63	\$3,037,630.68
CHORE/HOMEMAKER SUPPORTS	hourly	113	24	\$15.61	\$42,334.32
SUPPORTED EMPLOYMENT	hourly	368	170	\$32.47	\$2,031,323.20
SUPPORTED EMPLOYMENT	daily	248	170	\$33.37	\$1,406,879.20
NONSITE BASED DAY SUPPORTS	hourly	68	170	\$31.77	\$367,261.20
SITE BASED DAY SUPPORTS	daily	1,367	160	\$51.50	\$11,264,080.00
SENIOR DAY SUPPORTS	daily	113	160	\$51.50	\$931,120.00
EDUCATIONAL SUPPORTS	hourly	11	12	\$16.38	\$2,162.16
EDUCATIONAL SUPPORTS	need	11	1	\$1,135.50	\$12,490.50
FAMILY ASSISTANCE AND SUPPORT	hourly	710	200	\$17.71	\$2,514,820.00
RESPIRE CARE	hourly	676	150	\$11.35	\$1,150,890.00
RESPIRE CARE	daily	586	20	\$62.97	\$738,008.40
LATCH KEY SUPPORTS	hourly	26	480	\$7.95	\$99,216.00
TRANSPORTATION SUPPORT - TAXI	mileage	169	240	\$1.71	\$69,357.60
TRANSPORTATION SUPPORT - PRIV.	mileage	560	600	\$0.34	\$114,240.00
TRANSPORTATION SUPPORT	daily	1,175	180	\$8.28	\$1,751,220.00
TRANSPORTATION SUPPORT	bus pass	113	12	\$27.25	\$36,951.00

STATE: UTAH

F-8

EFFECTIVE DATE: January 1, 2002

ENVIRONMENTAL ADAPTATIONS	need	113	1	\$1,529.00	\$172,777.00
SPECIALIZED MED EQUIP/SUPPLIES	monthly	113	12	\$284.00	\$385,104.00
SPECIALIZED MED EQUIP/SUPPLIES	need	113	1	\$1,426.00	\$161,138.00
PERS EMERGENCY RESPONSE SYS	one-time	113	1	\$318.15	\$35,950.95
PERS EMERGENCY RESPONSE SYS	monthly	225	9	\$43.13	\$87,338.25
SPECIALIZED SUPPORTS - CHIROP.	hourly	169	6	\$45.42	\$46,055.88
SPECIALIZED SUPPORTS - ACCUP.	hourly	45	6	\$57.51	\$15,527.70
SPECIALIZED SUPPORTS - MASSAGE	hourly	169	12	\$45.41	\$92,091.48
SPECIALIZED SUPPORTS - DIET	monthly	68	12	\$42.77	\$34,900.32
SPECIALIZED SUPPORTS - COMM.	hourly	83	8	\$38.57	\$25,610.48
SPECIALIZED SUPPORTS - COUNSEL	hourly	26	12	\$68.13	\$21,256.56
PERSONAL ASSISTANCE	monthly	101	12	\$681.19	\$825,602.28
PERSONAL ASSISTANCE	hourly	56	170	\$10.84	\$103,196.80
GRAND TOTAL (sum of Column E):					\$92,182,157.30
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					3,822
FACTOR D (Divide total by number of recipients):					\$24,119
AVERAGE LENGTH OF STAY: <u>340 Days</u>					

APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1 ____ 2 ____ 3 ____ 4 X 5

Waiver Service Column A	Type of Unit	# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	TOTAL Column E
SUPPORT COORDINATION	monthly	3,822	12	\$225.00	\$10,319,400.00
SELF-DIRECTED SUPPORTS	hourly	589	48	\$24.18	\$683,616.96
COMMUNITY LIVING SUPPORTS	daily	1,432	303	\$132.11	\$57,322,000.56
COMMUNITY LIVING SUPPORTS	hourly	376	323	\$12.77	\$1,550,890.96
COMMUNITY LIVING SUPPORTS	hourly	297	498	\$22.39	\$3,311,615.34
CHORE/HOMEMAKER SUPPORTS	hourly	119	24	\$16.16	\$46,152.96
SUPPORTED EMPLOYMENT	hourly	388	170	\$33.61	\$2,216,915.60
SUPPORTED EMPLOYMENT	daily	261	170	\$34.54	\$1,532,539.80
NONSITE BASED DAY SUPPORTS	hourly	71	170	\$32.88	\$396,861.60
SITE BASED DAY SUPPORTS	daily	1,440	160	\$53.30	\$12,280,320.00
SENIOR DAY SUPPORTS	daily	119	160	\$53.30	\$1,014,832.00
EDUCATIONAL SUPPORTS	hourly	12	12	\$16.95	\$2,440.80
EDUCATIONAL SUPPORTS	need	12	1	\$1,175.24	\$14,102.88
FAMILY ASSISTANCE AND SUPPORT	hourly	747	200	\$18.32	\$2,737,008.00
RESPIRE CARE	hourly	712	150	\$11.74	\$1,253,832.00
RESPIRE CARE	daily	617	20	\$65.17	\$804,197.80
LATCH KEY SUPPORTS	hourly	28	480	\$8.22	\$110,476.80
TRANSPORTATION SUPPORT - TAXI	mileage	178	240	\$1.76	\$75,187.20
TRANSPORTATION SUPPORT - PRIV.	mileage	589	600	\$0.35	\$123,690.00
TRANSPORTATION SUPPORT	daily	1,238	180	\$8.57	\$1,909,738.80
TRANSPORTATION SUPPORT	bus pass	119	12	\$28.20	\$40,269.60

STATE: UTAH

Γ-10 EFFECTIVE DATE: January 1, 2002

ENVIRONMENTAL ADAPTATIONS	need	119	1	\$1,582.51	\$188,318.69
SPECIALIZED MED EQUIP/SUPPLIES	monthly	119	12	\$294.00	\$419,832.00
SPECIALIZED MED EQUIP/SUPPLIES	need	119	1	\$1,476.00	\$175,644.00
PERS EMERGENCY RESPONSE SYS	one-time	119	1	\$329.28	\$39,184.32
PERS EMERGENCY RESPONSE SYS	monthly	237	9	\$44.63	\$95,195.79
SPECIALIZED SUPPORTS - CHIROP.	hourly	178	6	\$47.00	\$50,196.00
SPECIALIZED SUPPORTS - ACCUP.	hourly	47	6	\$57.51	\$16,274.22
SPECIALIZED SUPPORTS - MASSAGE	hourly	178	12	\$47.00	\$100,392.00
SPECIALIZED SUPPORTS - DIET	monthly	71	12	\$44.26	\$37,709.52
SPECIALIZED SUPPORTS - COMM.	hourly	87	8	\$39.91	\$27,777.36
SPECIALIZED SUPPORTS - COUNSEL	hourly	28	12	\$70.51	\$23,691.36
PERSONAL ASSISTANCE	monthly	107	12	\$705.00	\$905,220.00
PERSONAL ASSISTANCE	hourly	59	170	\$11.21	\$112,436.30
GRAND TOTAL (sum of Column E):					\$99,937,961.22
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					3,822
FACTOR D (Divide total by number of recipient					\$26,148
AVERAGE LENGTH OF STAY: <u>340 Days</u>					

APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

Waiver Year 1 ____ 2 ____ 3 ____ 4 ____ 5 X

Waiver Service Column A	Type of Unit	# Undup. Recip. (Users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	TOTAL Column E
SUPPORT COORDINATION	monthly	3,822	12	\$233.00	\$10,686,312.00
SELF-DIRECTED SUPPORTS	hourly	619	48	\$25.02	\$743,394.24
COMMUNITY LIVING SUPPORTS	daily	1,504	303	\$136.73	\$62,309,501.76
COMMUNITY LIVING SUPPORTS	hourly	395	323	\$13.21	\$1,685,397.85
COMMUNITY LIVING SUPPORTS	hourly	312	498	\$23.17	\$3,600,061.92
CHORE/HOMEMAKER SUPPORTS	hourly	125	24	\$16.72	\$50,160.00
SUPPORTED EMPLOYMENT	hourly	407	170	\$34.78	\$2,406,428.20
SUPPORTED EMPLOYMENT	daily	274	170	\$35.74	\$1,664,769.20
NONSITE BASED DAY SUPPORTS	hourly	75	170	\$34.03	\$433,882.50
SITE BASED DAY SUPPORTS	daily	1,512	160	\$55.16	\$13,344,307.20
SENIOR DAY SUPPORTS	daily	125	160	\$55.16	\$1,103,200.00
EDUCATIONAL SUPPORTS	hourly	12	12	\$17.54	\$2,525.76
EDUCATIONAL SUPPORTS	need	12	1	\$1,216.37	\$14,596.44
FAMILY ASSISTANCE AND SUPPORT	hourly	785	200	\$18.96	\$2,976,720.00
RESPIRE CARE	hourly	748	150	\$12.15	\$1,363,230.00
RESPIRE CARE	daily	649	20	\$67.45	\$875,501.00
LATCH KEY SUPPORTS	hourly	29	480	\$8.50	\$118,320.00
TRANSPORTATION SUPPORT - TAXI	mileage	187	240	\$1.82	\$81,681.60
TRANSPORTATION SUPPORT - PRIV.	mileage	619	600	\$0.36	\$133,704.00
TRANSPORTATION SUPPORT	daily	1,301	180	\$8.86	\$2,074,834.80
TRANSPORTATION SUPPORT	bus pass	125	12	\$29.18	\$43,770.00

STATE: UTAH

Γ-12 EFFECTIVE DATE: January 1, 2002

ENVIRONMENTAL ADAPTATIONS	need	125	1	\$1,637.89	\$204,736.25
SPECIALIZED MED EQUIP/SUPPLIES	monthly	125	12	\$304.29	\$456,435.00
SPECIALIZED MED EQUIP/SUPPLIES	need	125	1	\$1,527.66	\$190,957.50
PERS EMERGENCY RESPONSE SYS	one-time	125	1	\$340.80	\$42,600.00
PERS EMERGENCY RESPONSE SYS	monthly	249	9	\$46.19	\$103,511.79
SPECIALIZED SUPPORTS - CHIROP.	hourly	187	6	\$48.64	\$54,574.08
SPECIALIZED SUPPORTS - ACCUP.	hourly	50	6	\$59.52	\$17,856.00
SPECIALIZED SUPPORTS - MASSAGE	hourly	187	12	\$48.64	\$109,148.16
SPECIALIZED SUPPORTS - DIET	monthly	75	12	\$45.80	\$41,220.00
SPECIALIZED SUPPORTS - COMM.	hourly	91	8	\$41.30	\$30,066.40
SPECIALIZED SUPPORTS - COUNSEL	hourly	29	12	\$72.97	\$25,393.56
PERSONAL ASSISTANCE	monthly	112	12	\$729.67	\$980,676.48
PERSONAL ASSISTANCE	hourly	62	170	\$11.60	\$122,264.00
GRAND TOTAL (sum of Column E):					\$108,091,737.69
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:					3,822
FACTOR D (Divide total by number of recipients):					\$28,281
AVERAGE LENGTH OF STAY: <u>340 Days</u>					

EXPLANATION OF D-CHART ESTIMATES

RATES: Rates paid by DSPD for similar state-funded services were used when Medicaid rates were not currently established.

COSTS: Cost increases shown for waiver year five reflects an increases in the C Value and inflation and not a per capita increase in utilization (units) of services. Per capita utilization is expected to remain relatively constant through year five of the current waiver authorization period.

APPENDIX G-3: METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Community Living Supports

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify):
Respite Care

Following is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Medicaid reimbursement rates paid to residential providers for habilitation services will be individualized based on the client's person centered plan. Clients may choose daily staff hours for night supervision, daily living supports, person centered outcomes supports, and additional weekend supports as well as services from medical professionals. The daily rate will be set prospectively and will generally be based on average historical costs as the best indicator of future program costs.

Clients are responsible to pay room and board directly to their landlord and purchase food out of their personal income. The Division of Services for People with Disabilities has a state funded program to assist clients to pay for housing. The daily Medicaid reimbursement rate will exclude all room and board costs.

Room and board is defined as occupancy costs in buildings in which clients reside except for Treatment Repair and Maintenance/Modifications. Treatment Repair and Maintenance Modifications are defined as expenses related to client needs, damages caused from client behavior, damage from wheel chairs, etc., and items such as ramps, rails, widening of hall or door entries, or other related special repairs or improvements needed by clients. Also included in this definition are repairs related to damage caused by clients' behavior such as holes in walls or doors, broken light fixtures, additional carpet cleaning, broken windows, or other damage caused directly by the client behavior,

or damage from wheelchairs or walkers on walls, floors, steps, etc.

Occupancy costs include building depreciation, rent, interest expense, utilities, repairs and maintenance, modifications, property taxes and insurance, some equipment such as beds or couches, food served to clients, and other costs related to the above. Personnel costs related to room and board include staff time for support workers that maintain buildings. That portion of administration costs that directly relates to the above room and board expenses are also included in room and board.

Annual Provider Cost Reports will be completed by providers and periodically used to rebase rates. Actual copies of the Provider Cost Reports and Definitions are available at the State Medicaid Agency for review.

**APPENDIX G-4: METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD
EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER**

Check one:

- X** The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.
- _____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: ICF/MR

On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services **WHILE THE INDIVIDUAL WAS ON THE WAIVER.**

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began **AFTER** the person's first day of waiver services and ended **BEFORE** the end of the waiver year **IF** the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred **BEFORE** the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

FACTOR D' (cont.)

Factor D' is computed as follows (check one):

- _____ Based on HCFA Form 2082 (relevant pages attached).
- X** Based on HCFA Form 372 for year FY99 of waiver # 0158.90.R.1
(preceding version of this waiver), which serves a similar target
population. The FY99 figure of \$6,580 is inflated to a FY2000 value
based on actual MCPI factor of 3.5 % ($\$6,580 \times 103.5\% = \$6,810$). An
annual inflation factor of 3.5% is then added for each of the 5 years to
compute the cost neutrality formulas for that year.
- _____ Based on a statistically valid sample of plans of care for individuals with
the disease or condition specified in item 3 of this request.
- _____ Other (specify):

APPENDIX G-6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

- ☐ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.
- ☒ Based on actual expenditures shown on HCFA Form 372 for year FY99 of waiver # 0158.90.R.1 (preceding version of this waiver), which reflect costs for an institutionalized population at this LOC. The FY99 figure of \$54,368 is inflated to an FY2000 value based on actual MCPI factor of 3.5 % ($\$54,368 \times 103.5\% = \$56,271$). An annual inflation factor of 3.5% is then added for each of the 5 years to compute the cost neutrality formulas for that year.
- ☐ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.
- ☐ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.
- ☐ Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.

APPENDIX G-7

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

Factor G' is computed as follows (check one):

_____ Based on HCFA Form 2082 (relevant pages attached).

 X Based on actual expenditures shown on HCFA Form 372 for year FY99 of waiver # 0158.90.R.1 (preceding version of this waiver), which reflect costs for an similar target population. The FY99 figure of \$2,868 is inflated to an FY2000 value based on actual MCPI factor of 3.5% ($\$2,868 \times 103.5\% = \$2,968$). An annual inflation factor of 3.5% is then added for each of the 5 years to compute the cost neutrality formulas for that year.

_____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_____ Other (specify):

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1

FACTOR D:	<u>\$22,863</u>		FACTOR G:	<u>\$58,240</u>
FACTOR D':	<u>\$ 7,049</u>		FACTOR G':	<u>\$ 3,072</u>
TOTAL:	<u>\$29,912</u>	≤	TOTAL:	<u>\$61,312</u>

YEAR 2

FACTOR D:	<u>\$22,191</u>		FACTOR G:	<u>\$60,278</u>
FACTOR D`:	<u>\$ 7,296</u>		FACTOR G`:	<u>\$ 3,180</u>
TOTAL:	<u>\$29,487</u>	≤	TOTAL:	<u>\$63,458</u>

YEAR 3

FACTOR D:	<u>\$24,119</u>		FACTOR G:	<u>\$62,388</u>
FACTOR D`:	<u>\$ 7,551</u>		FACTOR G`:	<u>\$ 3,290</u>
TOTAL:	<u>\$31,670</u>	≤	TOTAL:	<u>\$65,678</u>

YEAR 4

FACTOR D:	<u>\$26,148</u>		FACTOR G:	<u>\$64,571</u>
FACTOR D`:	<u>\$ 7,815</u>		FACTOR G`:	<u>\$ 3,406</u>
TOTAL:	<u>\$33,963</u>	≤	TOTAL:	<u>\$67,977</u>

STATE: UTAH

Γ-22 EFFECTIVE DATE: January 1, 2002

YEAR 5

FACTOR D: \$28,281

FACTOR G: \$66,831

FACTOR D': \$ 8,088

FACTOR G': \$ 3,525

TOTAL: \$36,369

\leq

TOTAL: \$70,356

APPENDIX G-9

WAIVER SERVICES PROVIDER REIMBURSEMENT RATE SETTING METHODOLOGIES - MAXIMUM ALLOWABLE RATES

A. DEPARTMENT OF HUMAN SERVICES RESPONSIBILITY TO SET WAIVER RATES UNDER CONTRACT WITH THE DEPARTMENT OF HEALTH

The Department of Human Services (DHS) has entered into an administrative agreement with the Department of Health, Division of Health Care Financing (DHCF) to set 1915c HCBS waiver rates for waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915c HCBS Waiver program and other applicable Medicaid rules. Since DHS usually sets rates at or close to the statistical mean, DHS also assures compliance with Medicaid payment requirements. Medicaid requires that rates for many services not exceed the prevailing charges. Prevailing charges are described at 42CFR § 405.504 and are set at the 75 percentile. The CFR lists other criteria regarding reasonable cost for Medicaid cost-of-service contracts when prevailing charge regulations do not apply. These are found and described at 42CFR § 405.501 and may be used as applicable.

B. AUTHORITY UNDER STATE DIVISION OF FINANCE RULE 33-3-217

DHS has the authority to set rates under the Utah State Department of Administrative Services (DAS), Division of Finance, Rule 33-3-217. This rule sets forth the parameters for open-ended, rate setting within DHS. Requirements for this rule are listed below.

3. All qualified providers can have a contract (no guarantee of placements), or in other words DHS must have a Request for Proposal (RFP) process that meets purchasing requirements.
4. DHS has a rate setting process that establishes reasonable rates.
5. DHS provides for due process to providers that have complaints.

C. COST PRINCIPLES

When setting rates and establishing budgets for cost of service contracts, DHS uses federal and department cost principles. These are described in the Bureau of Contract Management, Contract Information Manual, found on the DHS web site at <http://www.hsofo.state.ut.us/Contract.htm>. Additional references are given there for circulars containing the federal cost principles. These are issued by the federal Office of Management and Budget (OMB).

D. RATIONALE

5. The Department of Human Services has opted to provide many services using a fixed rate for multiple providers. This allows DHS the flexibility of using many providers across the state and increasing placement options across the state and within communities. Multiple providers are able to more readily respond to changing service demands. The DHS Bureau of Contract Management (BCM) has overall responsibility for the rate setting process within DHS. The setting of rates is based on a cooperative process between BCM and each division within DHS. Each division is responsible to determine and define the service code and service components within each code. When a division establishes a new service code, they work with BCM to determine the rate to be set for that service. BCM also reviews rates on an ongoing basis and sets (establishes) a DHS Maximum Allowable Rate (MAR) level or Cap for that rate.
6. Each division determines the actual amount to be paid to providers that is not more than the MAR rate level. Divisions make this determination based on available budget and other considerations. Divisions continue to develop new services and to determine the initial payment rate (provisional rate) for those services. BCM will review the proposed new service code and consult with the division and DHCF on determining an acceptable initial rate for the service. BCM gives authorization for the initial (provisional) rate and forwards a rate request form to finance for input on USSDS and to DCHF for input on MMIS.

E. OVERVIEW OF THE RATE SETTING METHODOLOGY

1. There are several methods DHS uses to reimburse providers of services to DHS clients. The DHS Rate Handbook outlines the procedures for setting rates for DHS providers. These methodologies include the use of: (1) the Request for Proposal (RFP) process for cost-reimbursement contracts, (2) sole source contracts, and (3) rate-based unit-of-service contracts. This statement provides the authority and methodologies used for setting and reviewing the rates paid to providers using rate-based unit-of-service contracts with DHS.
2. DHS rates are set and paid on a prospective basis. This means that rates are set based on the market. Although actual costs may decrease or increase, providers are not expected or allowed to refund or bill for differences between actual current costs and rates. Rates are set based on the current market value of services rendered. This is sometimes referred to as the prevailing charge or rate. The nature and requirements of each of the services are defined by the various Divisions within DHS in accordance with the general description of those services outlined in the RFP and contract. Determination of current market value of services is determined by surveying current providers of such services to determine charges for those services or, in the alternate, the actual cost to provide services is used to set rates in lieu of market charges.
3. When data show the market value of services to be tightly clustered among

various service providers, statistical measures of central tendency (e.g., mean, median, mode, and/or weighted average) are used. This establishes the most equitable rate that will assure a sufficient supply of service providers and concurrently pay a fair market rate. Measures of central tendency are best applied when data are clustered or normally distributed. When market conditions do not validate these assumptions, other measures will be allowed for use in setting rates for services including cost accounting measurements and/or those commonly used under Medicare or Medicaid programs. This also applies to rates receiving Medicaid reimbursements.

4. To insure the greatest possible integrity of data supplied by providers, the staff from BCM or the DHS Bureau of Internal Review and Audit may audit data. In addition, non-representative (outlier) survey data may also be dropped from the survey if it is deemed to unfairly bias the results. An example of this would be a small service provider with exceptionally high or low rates that are not representative of the industry and market at large.

F. RATE SETTING METHODS

There are four principal methods used in setting the DHS Maximum Allowable Rate level for all covered waiver services. Each method is designed to determine a fair market rate. Because DHS provides services using various funding sources, including Title XIX, Title XX, Title IV-E among others, adjustments to the following processes may be deemed necessary on occasion to comply with funding requirements. Additionally, the process may be adjusted on occasion to account for common factors such as the geographical location of service delivery, absentee factors, or division budget constraints, etc.

1. Existing Market Survey or Cost Survey of Current Providers.

This methodology surveys existing providers to determine their actual cost to render a service. This would include direct labor, supervision, administration, non-labor costs allocated to the purchased service and the basis of cost allocations. The surveys are designed to assure all providers are reporting costs in a standardized manner and within allowable costs parameters established by DHS. Surveys are examined to determine if cost definitions, allocations and reporting are consistent among respondents and accurately include reasonable costs of business. The rate is set using a measure of central tendency such as median, mode or weighted average and adjusted if necessary to reflect prevailing market conditions. (For example, a large provider may distort data and smaller providers may have substantially different costs. Failure to adjust for market realities may result in lack of available providers if the rate is set too low, or unnecessarily paying too much if the rate is set too high.)

2. Component Cost Analysis

The estimated cost of each of the various components of a service code (rent, treatment, administration, direct labor, non-labor costs allocated to the service, etc) are determined and added together to determine a provisional rate. This method is often used for a new or substantially modified service that does not currently exist in the market place. Provisional rates are designed to determine a fair market rate until historical data becomes available. At a later date when historical cost data does become available a market survey may be undertaken to confirm or adjust the rate.

3. Comparative Analysis

This method may be used when a similar service exists. Adjustments are made to reflect any differences in the new service. Where possible and to provide consistency of payments in the provider community, rates are set to maintain common rates for common services purchased by various agencies. If a proposed service duplicates an existing service being used by another agency or program, the existing rate may be used to provide consistency of payments in the provider community, if the companion agency rate is considered to be in line with the market.

4. Community Price Survey

Where a broad based market exists for a service outside of DHS, existing service providers may be surveyed to determine the prevailing market price for the service. Again, measures of central tendency such as median, mode or weighted average are used and adjusted if necessary to reflect prevailing market.

G. DATA VALIDATION

The Utah Department of Human Services strives to utilize the most accurate information in the rate setting process. DHS uses various methods to validate data used in setting rates; these include both internal and external statistical and accounting tests. The specific methods used are determined by the type of data collected (i.e., from Cost Surveys, Market Surveys, Comparative Analysis, etc.), historical reliability of data sources and demands on staff. The type of tests used are based on the nature of the rate being set. Various methods of validation are explained in the DHS Rate Handbook.

H. COST OF LIVING ADJUSTMENTS (COLA'S)

1. Cost of Living Adjustments (COLA's) to the DHS MAR rate level are made annually, effective with the beginning of each state fiscal year. In general, changes in the twelve month period ending in June (base period) are reflected in an adjustment for the state fiscal year beginning twelve months later (effective date). This interim period is used to collect data from the base period, as it becomes available. The COLA adjustment is scheduled to be completed by the

end of the calendar year to allow COLA information to be used in planning for the upcoming state fiscal year.

2. Changes in the MAR rates are based on changes in the cost of living as determined by broad based cost of living indices such as the Consumer Price Index (CPI-u) as published by the U.S. Department of Labor, or more representative local indices such as the Department of Workforce Services index of average Utah wages. The cost of living allowance is calculated by determining the percentage change in the index (or indices) and then applying that percentage change to the rate or rate components of established MAR rates. The MAR rates revisions are scheduled to be completed and published prior to the start of each state fiscal year.
3. COLA changes to a MAR are likely to be different from legislative rate changes funded in Division budgets. Legislative funding adjustments to Division rates are usually budget constrained and reflect a political perspective and may not be related to actual cost changes in rate components.

IV. SUPPORT COORDINATION SERVICE MONTHLY RATE

1. The Support Coordination covered waiver service provider rate is calculated using the cost survey of current providers methodology in general but includes an added procedure in which each fiscal year the State Medicaid Agency establishes specific cost center parameters to be used in calculating the annual MAR for waiver Support Coordination.
2. Support coordination activities covered by the MAR must be consistent with the definition of Support Coordination contained in Appendix B-1, and the Medicaid Home and Community-Based Services for Individuals with Development Disabilities or Mental Retardation provider manual.
3. Allowable Cost Centers
 - a. annual non-supervisory support coordination labor costs.
 - b. annual non-supervisory support coordination non-labor costs.
 - c. annual first line supervisory employee labor costs.
 - d. annual first line supervisory employee non-labor costs.
 - e. administrative costs associated with provision of support coordination service.
4. Support Coordination MAR Formula

coord.]

Monthly per client rate = $\frac{[(a + b + c + d + e) / (\# \text{ clients receiving spt.}]}{12 \text{ months}}$